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Hypnosis in Clinical Social Work Practice: What Contributes To Its Under-Utilization?

Amanda Olson
St. Catherine University

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Hypnosis in Clinical Social Work Practice:
What Contributes To Its Under-Utilization?

Submitted by Amanda Olson
May 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present their findings. This project is neither a Master's thesis nor a dissertation.

School of Social Work
St. Catherine University & University of St. Thomas
Saint Paul, Minnesota

Committee Members:
Sarah Ferguson, MSW, MA, PhD, LISW (Chair)
Beverly Caruso, MSW, LICSW
Bruce Eisenmenger, MA, ABD, LP

Abstract

Within the social work profession the clinical practice of hypnosis has generally been under-utilized and under-researched. Therefore, the aim of this study was to explore some of the components related to its lack of use in the profession. Qualitative interviews were conducted with four LICSW respondents who practice clinical hypnosis and three LICSW respondents who do not practice hypnosis. Content analysis was used to evaluate the data from the transcripts. Limited exposure and understanding of hypnosis affected respondents' opinions regarding the alignment of hypnosis with the social work profession and code of ethics. Concerns surrounding public and provider apprehensions were cited in relation to stage entertainment and media misconceptions. Yet, LICSW respondents who use hypnosis described it as a healing and client empowering intervention. Overall, respondents described that the macro-level lens of social work may contrast with the amount of specialized micro-level training needed for hypnosis practice. Some respondents also identified that limited training in theory and clinical application during graduate school may affect the amount of micro-level social work research in the field. Moreover, respondents described limited exposure to education, related trainings, and publications on hypnosis during graduate training and within their professional careers. Discussion of the research findings accentuated the healing and empowering benefits of hypnosis in contrast to the general population misconceptions. The importance of adhering to the social work code of ethics was also emphasized in order to maintain an upstanding practice. Implications for hypnosis training and education in the social work profession were also provided.

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Hypnosis in Clinical Social Work Practice:

What Contributes to its Under-Utilization?

Despite the fact that hypnosis has been utilized in medical and psychological practice for over 300 years, its definition, understanding, and acceptance as a form of treatment has taken many turns, and continues to evolve today (Kirsch, Lynn, & Rhue, 1993). Historically, it has been used as a direct form of treatment in the alleviation of medical symptoms for which the patient sought relief (Kirsch et al., 1993), as an anesthetic prior to surgery (Upshaw, 2006), and as a means of accessing dissociated traumatic memories (Gravitz, 1994). However, as hypnosis has evolved over centuries' time it has become better known as an adjunct tool used in combination with other therapeutic methods such as, psychodynamic therapy, cognitive behavioral therapy, or medical treatment, and often is referred to as *hypnotherapy* (Kirsch et al., 1993; Voit & DeLaney, 2004). As an adjunct tool it has been used in the treatment of many psychological concerns including phobias (Gravitz, 1994), acute stress (Bryant, Moulds, Guthrie, & Nixon, 2005), pain management (Askay, Patterson, Jensen, & Sharar, 2007; Lioffi, White, & Hatira, 2006; Smith, A. Barabasz, & M. Barabasz, 1996) and many others. In general, the goal of clinical hypnosis is to positively impact a person's behaviors, sensory experiences, and conscious reflection of themselves (Snow & Warbet, 2010). Although, like all therapeutic modalities, the effects of hypnosis vary based on the presenting concern of the individual and their personal response (American Society of Clinical Hypnosis, n.d.a).

The theoretical definition of hypnosis has been an area of debate between researchers and practitioners for almost as long as it has been in practice (Council,

Gravitz, Hilgard, & Levitt, 2000). It has been described as both an individual ability to experience an altered state of consciousness and inner focus (Voit & DeLaney, 2004), and as a set of procedures performed by a practitioner that induce focused concentration (Council et al., 2000; Wagstaff, 2008). Regardless of the definition, many individuals describe similar reactions to the experience such as, deep relaxation, acute attention, and inner concentration (American Society of Clinical Hypnosis, n.d.a). The process can be used to encourage positive mental imagery, provide suggestion (based upon the client's request) that may make a greater impact during the relaxed state, or to explore past events that may be contributing to current problems (American Society of Clinical Hypnosis, n.d.a).

The popularity and reputation of hypnosis has also waxed and waned over time, and appears to have been impacted by several factors. The scientific community has been challenged with coming to a conclusive understanding of the theoretical and biological basis of hypnosis (Council, et al., 2000; Sarbin & Coe, 1979). Gaps in fully understanding the process has prompted misconceptions that hypnosis can be dangerous, and may lead people to lose control of themselves or fall under the *spell* of the hypnotist (Lynn, Myer, & Mackillop, 2000; Upshaw, 2006; Wagstaff, 2008). Stage hypnotists and the media have exploited these general fears and misconceptions for their own entertainment value, which has in turn perpetuated its misunderstanding (Lynn et al., 2000). These exploited images of hypnosis appear to be ingrained in the collective psyche of American culture, and may be a contributing factor in the opinion and under-utilization of hypnosis within the social work community. The risk of *pseudo* memories, described as false memories or images that may emerge during hypnotic memory

retrieval, has been an additional concern related to hypnosis since the 1980s (Upshaw, 2006). Although practitioners have taken steps to avoid this possibility since then, it appears to have added an additional negative image to the process of hypnosis in the media and scientific community (Upshaw, 2006). Professional organizations such as the Society for Clinical and Experimental Hypnosis (SCEH) and the American Society of Clinical Hypnosis (ASCH) provide ethical codes of conduct, ongoing training, and continuing education opportunities for professionals using hypnosis in the field, which can support practitioners in protecting clients and ensuring informed consent.

In the medical and mental health field, the use of Complementary and Alternative Medicine (CAM) is on the rise (National Center for Complementary and Alternative Medicine [NCCAM], 2008). These practices are used either in conjunction with or in place of mainstream treatments (NCCAM, 2008). Clinical hypnosis falls under the definition as a complementary tool that can be used in a variety of professions, including social work (NCCAM, 2008). However, the amount of published literature on the subject of hypnosis in the social work profession reflects that hypnosis may currently be under-utilized as a valuable intervention.

Therefore, this paper intends to explore the literature surrounding the historical, theoretical, and practice implications associated with clinical hypnosis. Overall, this paper aims to investigate the factors that may be contributing to the under-utilization of clinical hypnosis in social work practice. Potential reasons including the misconceptions of hypnosis will be explored. Additional factors such as the medical referral process, third-party payers, limited research and education, and the threat of legal suits will also be discussed.

Literature Review

History of Hypnosis

Historically, hypnosis has waxed and waned in popularity and utilization as a therapeutic treatment approach. Its roots appear to be connected to the religious and spiritual practices of shamans in ancient times, in which practitioners induced trance-like states in their subjects for various healing purposes through non-scientific means (Upshaw, 2006). The healing that occurred through these practices was often given religious or spiritual explanations. As hypnosis began entering the medical field, its practitioners often retreated to these spiritual explanations when no medical explanations could be identified (Upshaw, 2006). These beginning stages of hypnosis as a spiritual practice appear to have later affected its difficulty in becoming established in the scientific community (Upshaw, 2006).

1700s - Mesmerism. In recorded history, hypnosis can be traced back to Franz Anton Mesmer, an eccentric medical physician who practiced what he called *animal magnetism* during the 1700s (Kirsch et al., 1993; Upshaw, 2006). Mesmer believed that a magnetic fluid, which connected all living creatures, the earth, and the entire universe, moved together in a harmonizing ebb and flow. When an individual became ill it was, because their magnetic fluid was out of harmony with this connection (Kirsch et al., 1993; Upshaw, 2006). To realign the person's animal magnetism, Mesmer would make physical contact with the subjects and wave his hands over their bodies (Kirsch et al., 1993). Historical information states that his first subject probably had a seizure disorder, because she responded to the practice by convulsing (Kirsch et al., 1993). Consecutive subjects then modeled her behavior and responded in the same way. This convulsive-

type behavior was also a typical and expected response of individuals who had undergone an exorcism by spiritual leaders of the time (Kirsch et al., 1993). The practice became known as *mesmerism*, which is also the root of the modern English word, *mesmerize*. While practicing mesmerism on his own during the late 1700s, one of Mesmer's students, Marquis de Puysegur, observed that his subjects had a very different response to the process (Kirsch et al., 1993). His subjects appeared to be in a deep sleep, however, were able to talk and respond to questions asked by Puysegur. This sleep-like behavior eventually became known as the typical response for subjects, and the convulsive reaction extinguished (Kirsch et al., 1993). Due to the difficulty in proving causality in mesmerism, the medical field scrutinized the practice. A French committee formed by Louis XVI in 1785 investigated mesmerism, and discredited the work concluding that it was unscientific, and the changes that the subjects experienced were due only to the person's imagination (Kirsch et al., 1993; Upshaw, 2006). Although his practices were unscientific in means, Mesmer is often credited for being the first practitioner to bring hypnosis into the medical field.

Early to mid-1800s - Hypnotism. Mesmerism fell from popularity until the 1800s when another group of English physicians, including James Braid, began studying the practice. Braid formed a new theory of the trance-like state, and renamed the practice, *hypnotism*, after the Greek word for sleep, *hypno* (Kirsch et al., 1993; Upshaw, 2006). He identified a biological and more scientific understanding of hypnosis by describing it as a response of the nervous system (Kirsch et al., 1993; Upshaw, 2006). James Esdaile, a Scottish surgeon, used hypnotism in India as an anesthetic prior to

surgery. Although successful in producing positive results, his application of hypnotism lost favor when chemical anesthetics were introduced in the early 1840s (Upshaw, 2006).

Late 1800s to mid-1900s – Influences of Charcot, Freud, Janet, & Erickson.

During the late 1800s, two schools of hypnosis opened for the purposes of studying the phenomenon; the School of Nancy and the School of Salpetriere (Kirsch et al., 1993; Upshaw, 2006). The School of Nancy studied the phenomenon of hypnosis as a treatment form, and viewed subjects' responses to suggestion as an expected response based on the procedure (Kirsch et al., 1993; Upshaw, 2006). In contrast, the School of Salpetriere viewed the phenomenon of hypnosis as pathological, and believed that only the mentally unstable would respond to suggestion (Kirsch et al., 1993; Upshaw, 2006). Jean-Martin Charcot, a prominent neurologist of the period and founder of the School of Salpetriere, hypothesized that hypnosis was a neuro-pathological state in which thoughts could be disassociated from one's awareness (Kirsch et al., 1993; Winsor, 1993). He demonstrated this by inducing and then removing conversion symptoms in his subjects. Sigmund Freud, a student of Charcot at the Salpetriere School, later used this theory of dual-consciousness to develop his own theory of the unconscious, including the use of free association (Kirsch et al., 1993, Upshaw, 2006).

French psychologist, Pierre Janet, also began using hypnosis during this time to develop his theory of disassociation of traumatic memories (Gravitz, 1994). He believed that in order to find relief from symptoms the traumatic memories had to be traced back to their origins, and he often utilized hypnosis to aid in this process (Gravitz, 1994). According to Upshaw (2006) Freud struggled with consistently inducing a hypnotic state with his patients, and began suggesting that repressed memories could be accessed during

the waking state as well. He eventually abandoned the theory and practice of hypnosis for his process of psychoanalysis, which led to the disappearance of hypnosis from the medical and psychological field for several decades (Kirsch et al., 1993; Upshaw, 2006; Winsor, 1993). Milton Erickson, a medical physician, reevaluated its usefulness in the mid-1900s, and is known as the father of modern hypnosis (Council et al., 2000; Kirsch et al., 1993; Winsor, 1993). Erickson developed many induction techniques based on metaphoric stories, and his advancements in hypnosis are attributed to its continued use in practice today (Kirsch et al., 1993; Winsor, 1993).

Mid-1900s to present - Revival of hypnosis. The years following World War II prompted a revival of hypnosis as a therapeutic tool (Council et al., 2000; Upshaw, 2006). Hypnosis showed promise as a therapeutic aid for returning war veterans suffering the effects of trauma, and national foundations such as, the National Institute for Mental Health, Office of Naval Research, National Science Foundation, and others served as funding sources for further research (Council et al., 2000; Upshaw, 2006). This surge in funding and research prompted the endorsement of hypnosis by several professional associations, including the American Psychological Association, which formed its own special division aimed at researching hypnosis called Division 30 (Council et al., 2000). In 1949, Jerome Schneck, an American psychiatrist, formed the Society for Clinical and Experimental Hypnosis, and began the *International Journal of Clinical and Experimental Hypnosis* aimed at the researching hypnosis (Council et al., 2000). Additionally, in 1958 Milton Erickson founded the American Society for Clinical Hypnosis, and established the *American Journal of Clinical Hypnosis* with the intention of focusing more on hypnosis in clinical practice (Council et al., 2000).

The history of hypnosis has been strewn with proponents and opponents of its practice leading to its popularity and disappearance over several centuries. While its development has been quite valuable in the evolution into a modern therapeutic tool, the difficulties in understanding hypnosis from a biological perspective have been an area of ongoing debate. The following section will explore the modern theories, techniques, and characteristics that form the current therapeutic technique of clinical hypnosis.

Theories, Techniques, and Characteristics of Hypnosis

Theories of hypnosis. The theoretical understanding of hypnosis has changed dramatically throughout history, and a firm definition is still an area of controversy between practitioners and researchers today (Council et al., 2000). Some theorize that hypnosis lies within an individual's ability to experience a relaxed state of consciousness, sometimes referred to as an altered state, in which increased concentration, focused thought, and suggestibility are possible (American Society of Clinical Hypnosis, n.d.a; Fromm, 1976; Kirsch et al., 1993; Lankton, 2001; Payne, Vickers, & Zollman, 2001; Voit & DeLaney, 2004). In contrast, some researchers have disagreed with the opinion of hypnosis as an altered state prompting some professional groups to accept the more neutral definition as a set of procedures and suggestions (Council et al., 2000; Wagstaff, 2008). In 1983, the American Psychological Association (APA) formed a committee entitled, Project Enlightenment aimed at formulating a professional definition of hypnosis in order to better separate its professional use from its non-professional use, such as in stage or entertainment hypnosis (Council et al., 2000). This definition, later published in the *APA Newsletter*, described hypnosis as an "altered consciousness" with the additional characteristics of relaxation, suggestibility, suspension

of critical evaluation, changes in memory processing, acute attention, dissociated reality, and several personality characteristics of hypnotizability (Council et al., 2000).

Approximately ten years later, this definition was re-written to reflect a more theoretically neutral description due to criticisms from some in the psychological community who did not believe in the theory of hypnosis as an altered state (Council et al., 2000). This new definition, which remains in place today, maintained the characteristics of hypnosis noted above, however, re-defined hypnosis as a set of procedures instead of an altered consciousness (Council et al., 2000). Wagstaff (2008) suggests that describing hypnosis in terms of concentration and attention instead of a description as an altered state may encourage those in the clinical community to be more open to the possibilities that hypnosis can offer. As earlier noted, this debate continues today, and the following will provide further details regarding the experience, procedures, and characteristics of hypnosis.

Trance. “If dreams are the royal road to the unconscious, hypnosis is the driveway leading to the castle; hopefully a shorter and more direct route than other methods...” (Voit & DeLaney, 2004, p. 14). Metaphorically, hypnosis can be seen as the shorter path to accessing the unconscious realm of the mind where ingrained patterns and beliefs can reside outside of conscious thought. The condition of heightened awareness or altered consciousness referred to as *trance* can be defined as an experience in which the threshold of consciousness is lowered allowing for increased access to the unconscious (Fromm, 1976; Voit & DeLaney, 2004). Fromm (1976) describes that during hypnosis the individual experiences a blurred sense of reality in which he or she can experience imagery and past memories as occurring in real-time while in trance. The

phenomenon is described as a type of disassociation or split between the witness of the imagery or memory (the observing ego), and the participant experiencing the phenomenon (the experiencing ego) (Knight, 1991; Fromm, 1976).

One of the more influential theories of the 20th century is that of Neodissociation Theory created by Hilgard (1991) (as cited in Kirsch et al., 1993). This theory contends that one's reality is organized by the executive ego in a hierarchical structure of multiple layers based on past experiences and the environment (as cited in Kirsch et al., 1993). During hypnosis, the conscious and unconscious are separated or *disassociated* from one another, which facilitates more direct access to the unconscious mind without having to filter through layers of previous experience (as cited in Kirsch et al., 1993). This process can allow for a new perspective and less resistance in dealing with past concerns that may be causing present-day problems (Payne et al., 2001; Voit & DeLaney, 2004).

Types of trance. Trance has been described as a naturally occurring phenomenon that for some individuals can occur several times per day (Knight, 1991; Voit & DeLaney, 2004). One example of this is the experience of *highway hypnosis* when the unconscious mind attends to driving while the conscious mind is engrossed in thoughts or a song on the radio (Voit & DeLaney, 2004). The similar phenomena of becoming consumed by a book, movie, or video game further points to the inherent state of trance, which places the control of the hypnosis experience in the hands of the recipient (Knight, 1991; Voit & DeLaney, 2004).

Trance can also be accessed through formal induction facilitated by a researcher or practitioner in a clinical setting (Kirsch et al., 1993; Vandenberg, 2005; Voit &

DeLaney, 2004; Winsor, 1993). During formal hypnotic induction, a subject's attention may become heightened and attuned towards the mind and body, the line between imagination and reality may become blurred, and the subject may more easily accept suggestion from the practitioner (Winsor, 1993). Focus may occur on past memories, biological processes or problems, visualization, or more abstract ideas such as ego strengthening (American Society of Clinical Hypnosis, n.d.a; Winsor, 1993). Researchers assert that the practitioner using hypnosis should be prepared to explore only the areas that he or she is competent in exploring outside of the hypnosis process (Kirsch et al., 1993; Voit & DeLaney, 2004).

Trance state techniques. The literature identifies a variety of techniques for inducing trance during hypnosis (Kirsch et al., 1993; Knight, 1991; Lankton, 2001; Vandenberg, 2005; Voit & DeLaney, 2004; Winsor, 1993). Brown and Fromm (1986) identify three styles of hypnotic induction: direct, indirect, and Ericksonian (as cited in Winsor, 1993). Other researchers have also described these styles without using these specific terms (Vandenberg, 2005; Voit & DeLaney, 2004; Kirsch et al., 1993).

Direct style. A direct style of hypnosis suggests that induction is best performed as a command from the practitioner to the subject (Vandenberg, 2005). Phrases such as, "Your eyes are getting heavy. You can barely keep them open," instructs the client to follow the directions of the practitioner. Vandenberg (2005) suggests that this style is more conducive to evoking a trance state, because it helps the subject to feel that they are in a safe and controlled environment. Use of conditional phrases such as, "I wonder if..." and "you might feel..." are avoided, because it detracts from the authority of the clinician (Vandenberg, 2005). In contrast, other researchers claim that a directive style of

induction is no longer used in modern practice, and may produce resistance to induction with hypnosis subjects (Knight, 1991; Winsor, 1993).

Indirect style. The indirect style of induction is described as utilizing a more permissive hypnotic method (Kirsch et al., 1993; Lankton, 2001; Winsor, 1993). Phrases such as, “You may soon feel more relaxed. I wonder when your pain may start to lessen. Soon you might experience that memory differently,” all place the practitioner in a facilitator role versus an authoritative role. Some researchers identify the indirect style as the most appropriate for modern-day practice, because it encourages the subject to explore their own hypnotic capabilities, including the practice of self-hypnosis (Winsor, 1993). The use of an indirect style also sends the message to the client that they are in control of the hypnosis session, and can choose whether or not to attend to the therapist’s suggestions (Lankton, 1991).

Ericksonian style. Physician, Milton Erickson, developed the indirect style of Ericksonian induction in the early to mid-1900s (Kirsch et al., 1993; Winsor, 1993). His style was based on using elaborate stories, metaphors, paradoxical, and confusion techniques to evoke trance (Kirsch et al., 1993; Vandenberg, 2005; Winsor, 1993). This style might be recommended for clients if their own critical self-reflection is creating challenges in the response to other hypnotic inductions (Vandenberg, 2005). Erickson and his followers believed that anyone could be hypnotized if the subject had gained adequate rapport with the practitioner, and the most appropriate technique was utilized (Winsor, 1993). On the contrary, many researchers believe that a subject’s ability to be hypnotized is more strongly connected to one’s own personal abilities versus the capabilities of the practitioner (Piccione, Hilgard, & Zimbardo, 1989; Smith et al., 1996).

Lankton (1991) identifies that researching the style of Ericksonian induction has been challenging, because the techniques are very individualized to the needs of the subjects.

The process of hypnotic induction. Regardless of the technique used, according to Snow & Warbet (2010), the process of hypnosis in the clinical setting occurs in three stages. The first stage, called the *preparation stage*, involves the process of building rapport with the client, gathering pertinent historical and present-day information, and gaining an understanding the client's goals for hypnosis (Snow & Warbet, 2010). This phase is important in the process of hypnosis, or any therapeutic relationship, as it helps to establish alliance between the client and practitioner.

The second stage is the *induction and trance phase* where the practitioner guides the client into trance, and through the exploration of the intended aim of hypnosis. The induction process can be done in a multitude of ways, and Lankton (2001) notes that the process is very individualized for each particular client. A few of these processes include: progressive body relaxation or counting backwards (Lankton, 2001), focused breathing or staring at a spot on the wall until the eyes close (Vandenberg, 2005), or commenting on the client's observable signs of relaxation as they occur (Kirsch et al., 1993). Knight (1991) recommends utilizing the social work principle of meeting the client where they are at, and therefore, using the induction technique that the client is most comfortable with and expects.

Once the client has reached a state of trance, the practitioner may utilize an array of interventions including, encouragement to explore imagery, the use metaphoric symbols to help the client tend to presenting problems (such as *climbing a mountain*), connecting present feelings to those from the past, and visualizing particular skills

(Knight, 1991). *Post-hypnotic suggestions*, such as, “you may find yourself feeling more confident today than yesterday,” are often given during this stage based upon the goals of hypnosis. The unconscious mind is believed to accept these suggestions, and incorporate them into the conscious behaviors of the self (Gravitz, 1994; Vandeberg, 2005). In essence, the post-hypnotic suggestion impacts the subjective reaction of the subject in a similar manner as that of objective reality (Gravitz, 1994).

During the third or *termination stage*, the practitioner assists the client in returning to their normal waking state of awareness. This is often accomplished by providing a flexible number of minutes to return the awareness to the room or by counting backwards from a particular number (Snow & Warbet, 2010).

Similarities between hypnotic induction techniques and mindfulness scripts.

Researchers describe the process of inducing hypnotic trance as being quite similar to the utilization of guided imagery and relaxation (Kirsch et al., 1993; Winsor, 1993). Qualitative research on the utilization of mindfulness strategies to alleviate chronic pain describe interventions such as, a guided body scan, focused breathing while in a seated position, and focused attention on body sensations (Morone, Lynch, Greco, Tindle, & Weiner, 2008). Reading a hypnosis induction script (Kirsch et al., 1993) can look quite similar to these mindfulness strategies, and both can be used for relaxation purposes and stress management (Winsor, 1993). In addition, Kirsch et al. (1993) notes that the type of relaxation reached during hypnosis is similar to the relaxation achieved during meditation. Response differences to hypnotic induction techniques and guided mindfulness scripts appear to lie within the characteristics and abilities of the subject to

enter into trance versus within the specific techniques themselves (American Society of Clinical Hypnosis, n.d.a; Kirsch et al., 1993; Piccione et al., 1989; Winsor, 1993).

Characteristics of hypnotizability. Researchers believe that there are certain cognitive and interpersonal aspects that are correlated with an individual's ability to be hypnotized (American Society of Clinical Hypnosis, n.d.a). The following will discuss research on the longitudinal stability of hypnotic capabilities (Piccione et al., 1989). Additionally, the correlations amongst hypnotizability and personal characteristics of creativity (Manmiller, Kumar, & Pekala, 2005), absorption (Council, Kirsch, & Hafner, 1986; Glisky, Tataryn, Tobias, Kihlstrom, & McConkey, 1991; Manmiller et al., 2005), and hypnotic expectancy (Council et al., 1986; Lynn, Snodgrass, Rhue, & Hardaway, 1987) will be reviewed.

Personality trait. A subject's ability to be hypnotized has been described as a characteristic similar to a personality trait, which is specific to each individual (American Society of Clinical Hypnosis, n.d.a.; Piccione et al., 1989; Winsor, 1993). A longitudinal study of 50 research subjects over a 25-year span of time found a statistically significant stability in their hypnotizability (Piccione et al., 1989). Using the 12-point Stanford Hypnotic Susceptibility Scale, a widely used scale developed and modified for clinical research with adults and children since the 1989 study (Askay, Patterson, Jensen, & Sharar, 2007; Bryant et al., 2005; Lioffi et al., 2006; Smith et al., 1996), researchers found a stability coefficient of .71 at the 25-year retest (Piccione et al., 1989). In addition, the median change of scores on the 12-point scale was only one point (Piccione et al., 1989). This median change is even more significant when interpersonal and

environmental changes are acknowledged, such as marriage, divorce, loss of loved ones, trauma, child birth, and so on (Piccione et al., 1989).

Creativity and absorption. In addition to the literature on the stability of individual hypnotizability, researchers have also investigated contributing personality and behavioral factors. Creativity (Manmiller et al., 2005) and absorption (Bryant, Guthrie, & Moulds, 2001; Council et al., 1986; Glisky et al., 1991; Manmiller et al., 2005) have both been linked to hypnotizability, however, the correlation of these factors is still somewhat unclear.

For the reference of the following studies, *absorption* is defined as an ability to become so fully engaged in an activity (such as reading, exercising, or watching a movie) that it is possible to experience an alternative reality or, in essence, *tune-out* reality (Glisky et al., 1991). Manmiller et al., (2005) utilized 429 college students in their study, and analyzed correlations between creativity, absorption, and hypnotizability. They found a moderate correlation ($r=.144$, $p<.006$) between creativity and hypnotizability, however, during further analysis found that creativity was more closely linked to absorption than hypnotizability ($t=3.33$, $p<.001$). The Glisky et al. (1991) study, which utilized over 2,000 subjects, found that those who scored high in absorption also tended to be hypnotizable, and subjects that rated low in absorption were equally split between being hypnotizable and being non-susceptible to hypnosis. Clinically, individuals with pathological symptoms of disassociation that replicate a state of absorption, such as in post-traumatic or acute stress disorders, phobias, and some personality disorders are also shown to be high in hypnotizability (Bryant et al., 2001; Winsor, 1993).

Expectations. Other studies have found associations between absorption, hypnotizability, and subject expectations. Council et al. (1986) studied the absorption levels of undergraduate psychology students within and outside of the context of hypnosis. In the study, half of the students completed a measurement scale for absorption, and half did not. The whole group was then offered the opportunity to participate in the hypnosis portion of the study, and of those, 90 students volunteered. The absorption scale was then administered to those who had not taken it. Council et al. (1986) found a higher correlation between absorption and hypnotizability when students in the group were administered the scale right before the hypnosis study. Therefore, their expectations about hypnosis appeared to increase the association between hypnotizability and absorption. Similar studies have also found a correlation between subject behavioral response under hypnosis and subject response expectations (Lynn et al., 1987). In review, it appears that the personality and behavioral factors that contribute to an individual's ability to be hypnotized are in need of further research to increase the support for their correlations.

Levels of hypnotizability. An individual's ability to be hypnotized can be categorized into high, motivated, and low (Winsor, 1993). Highly hypnotizable individuals can easily enter into trance, and are very *suggestible*, meaning they respond to the practitioner's direct or indirect suggestions (American Society of Clinical Hypnosis, n.d.a; Winsor, 1993). Children are thought to be high in hypnotizability until they reach adolescence when this ability may decline, but then stabilizes in adulthood (Winsor, 1993). Important characteristics of hypnosis also include the subject's trust and rapport with the practitioner, and their level of interest, motivation, and expectations during

hypnosis (Winsor, 1993). An individual who is positive and motivated towards the efficacy of hypnosis is more likely to benefit from the process. This is supported in the previously identified research on expectations (Council et al., 1986; Lynn et al., 1987). Individuals low in hypnotizability tend to report little to no difference in their state of awareness, and are not susceptible to hypnotic suggestion (American Society of Clinical Hypnosis, n.d.a; Winsor, 1993). Moreover, this information supports hypnosis as a collaborative process guided by the individual based on their ability and motivation, and not solely on the basis of the practitioner's skills or style.

Hypnosis as a Clinical Tool

Roberts (2001) hypothesizes that when emotionally charged experiences are not expressed or processed they become stored in the body on an unconscious level. Symptoms may then emerge psychologically or somatically as the voice of these experiences. When hypnotic interventions are apart of a comprehensive therapeutic approach they can serve as a means of communicating with and potentially releasing these stored experiences (Robert, 2001).

Research has identified multiple areas of clinical practice where hypnosis can be employed as a beneficial adjunct tool to treatment. Just a few of the clinical areas where hypnosis has shown positive effects include, phobia and anxiety disorders (Gravitz, 1994; Nugent, 1993), trauma (Bryant et al., 2005; Lesmana, Suryani, Tiliopoulos, & Jensen, 2010; Malon & Berardi, 1987), and pain management (Askay et al., 2007; Lioffi et al., 2006; Smith et al., 1996; Snow & Warbet, 2010) The following will discuss some of the available literature on these clinical areas.

Anxiety & phobias. Nugent (1993) used hypnosis in a series of single case design method. In one of the cases, he was working with a 39-year-old woman who identified a history of panic and severe anxiety. She reported that the weeks prior to her entry into therapy she had been experiencing and increasing amount of panic attacks that seemed to be getting worse. She had become increasingly avoidant of driving and, at times, of leaving her home. Nugent (1993) employed a cognitive-behavioral approach to treating the woman's panic and anxiety, and also introduced and withdrew an Ericksonian-style hypnotic intervention as a treatment tool during various intervals over a total of 36 days.

During the baseline phase (days one to six) the woman recorded having an average of six panic attacks per day, and rated her subjective intensity of the attacks at a six out of 10 points with 10 being the most intense. During the final phase of treatment (days 28 to 36) she identified having an average of 1.5 panic attacks per day, and described the intensity of the attacks as a two out of 10 points. Upon interview at the one month, three month, six month, one year, and two year follow-ups she stated that she had not experienced any further problems with anxiety or panic since ending the treatment (Nugent, 1993). The findings of Nugent (1993) show that the Ericksonian-style hypnosis intervention may have had a causal impact on the number and degree of the woman's panic attacks. Limitations to this research include difficulty in treatment generalization and threats to internal validity given the single case design of the study.

Similarly, Gravitz (1994) utilized case examples to illustrate how hypnosis can help to treat phobia and depression. In one case, a 58-year old woman identified a history of anxiety, and a phobia of flying. She attributed her fear to a memory she had as a child

in which she was flying alone when the pilot jokingly announced that they appeared to be “lost.” They were apparently unable to land on time due to excessive air traffic. As a child at the time, she did not understand the situation, and became overwhelmed by fear. During hypnosis, the woman shared the memory from the perspective of her childhood self. When she recalled the pilot saying they were “lost,” the therapist used a direct approach, and interjected the suggestion (by acting as the pilot) that the plane would be landing just a few minutes late. He then walked her through the imagery of a safe plane landing. After the hypnosis was completed the woman processed through her hypnosis experience, and described feeling as though she had gained a new perspective of the memory. She was thereafter able to fly successfully (Gravitz, 1994). The intervention in this case assisted the woman with altering her perception of the memory of flying. Gravitz (1994) states that the case example illustrates that a person’s perception and meaning of an event are an important element in shaping the reaction to it. In addition, imagined information provided during hypnosis can possibly make just as strong of an impact as objective reality (Gravitz, 1994). Again, the limitations of this case example include the difficulty in treatment generalization, and threats to internal validity.

Trauma. Similarly to Gravitz (1994), Lesmana et al. (2010) used a hypnosis intervention as a means of reframing a negative experience in order to encourage the development of an alternative understanding. In a longitudinal, quasi-experimental design, researchers implemented a hypnotic intervention with a focus on re-framing negative imagery associated with a terrorist bomb attack in Bali. The participants included a group of children between the ages of six and 12 diagnosed with post-traumatic stress disorder (PTSD) following the event. Of the 226 children in the study,

48 received the intervention. At the two-year follow-up, the treatment group showed a 77.1% improvement in PTSD symptoms compared to 24% in the control group.

Bryant et al. (2005) and Malon and Berardi (1987) showed similar effects in the treatment of trauma. In a quasi-experimental design, Bryant et al. (2005) studied 87 participants with a DSM-IV diagnosis of acute stress disorder. Over the course of six group sessions the researchers randomly assigned participants to groups of cognitive-behavioral therapy, supportive counseling, or cognitive-behavioral therapy and hypnosis. The results showed that the use of hypnosis in conjunction with cognitive-behavioral therapy produced a statistically significant ($p < .05$) decrease in the acute stress symptom of re-experiencing the traumatic event over cognitive-behavioral therapy or supporting counseling (Bryant et al., 2005). Likewise, Malon and Berardi (1987) utilized hypnosis during the course of therapy with women who had experienced abuse and trauma. They found that the intervention helped to decrease intrusive memories that were often a trigger to self-injurious behaviors, and provided participants with a greater sense of control over their emotions (Malon & Berardi, 1987).

Hypnosis and pain management. Research surrounding the use of hypnosis for pain management appears to be a more recent area of development in the Western world (Askay et al., 2007; Lioffi et al., 2006; Smith et al., 1996; Snow & Warbet, 2010). The following will provide a review of this available research.

As described earlier, one of the more prominent theories related to hypnotic trance is the process of disassociating the conscious mind from the unconscious mind (Kirsch et al., 1993). Several studies have identified the positive benefits of hypnotic disassociation for the management of pain in various settings (American Society of

Clinical Hypnosis, n.d.a; Askay et al., 2007; Grindstaff & Fisher, 2006; Lioffi et al., 2006; Smith et al., 1996). Qualitative research has shown support for the pain relief benefits of using alert, self-hypnosis to disassociate the mind from the body to block out distractions for long-distance runners and other athletes (Grindstaff & Fisher, 2006). Additional qualitative research on hypnosis and pain management identified that highly hypnotizable children, ages three to eight, (scoring between four to six points on the six-point Stanford Hypnotic Clinical Scale for Children) experienced decreased anxiety and pain, as well as increased feelings of control during painful oncology procedures (Smith et al., 1996). Children with low hypnotizability (scoring between zero to two on the scale) reported and were observed as being distracted by toys that were provided; however, did not report decreased anxiety or pain during the procedure (Smith et al., 1996). The highly hypnotizable children described becoming so engaged in the fantasy story (hypnotic induction through guided imagery) told by their parents that they did not even feel the physical pain of the injection (Smith et al., 1996). The hypnotic techniques helped both the children and their parents to feel more empowered during the treatments. The results of a similar study with children undergoing oncology treatments also provided a statistically significant decrease of anxiety and pain sensations while using self-hypnosis and topical cream as compared with a group that employed one-on-one attention from a therapist and topical cream (Lioffi et al., 2006).

One experimental design study utilizing adult subjects in an inpatient burn unit produced slightly conflicting results as compared to the previous two studies. In the design, researchers used both a taped hypnotic induction specifically formatted for burn wound care (experimental group), and a taped combination of silence, guided imagery,

and music (control group) (Askay et al., 2007). The study produced no significant differences between the two groups. Nonetheless, both groups reported a decrease in their experience of pain by an average of 10-12% following one intervention (Askay et al., 2007). However, it is arguable that all of the subjects in the study fell into the middle range of hypnotizability (between two and three points on the five-point Stanford Hypnotic Clinical Scale), and therefore, the control intervention may have actually induced trance for this group. Research is needed to further explore such elements.

Contraindications. Although hypnosis has shown support in the treatment of multiple psychological and medical concerns, it is not a universal answer to all problems, and can be contraindicated in certain areas (Kirsch et al., 1993; Knight, 1991). For example, hypnosis may be contraindicated for individuals who have difficulty experiencing a definitive line between objective reality and fantasy, such as with psychotic disorders, or individuals who may not be sufficiently stable in treatment, such as with Borderline Personality Disorder or Dissociative Identity Disorder (Kirsch et al., 1993). Additionally, hypnosis may not suit well for clients who are suspicious or hostile, have difficulty with boundaries, or those who fear losing control (Winsor, 1993). Yet, some practitioners assert that hypnosis may be beneficial to dubious candidates if the intervention is formatted to fit their goals and capacities (Winsor, 1993). In any case, informed consent should always be obtained, and the therapists should only utilize hypnosis for conditions that they would be competent in treating outside of hypnosis (Kirsch et al., 1993; Voit & DeLaney, 2004).

The Misconceptions of Hypnosis

As previously stated, clinical hypnosis can be used as an adjunct tool to psychotherapy (Kirsch et al., 1993; Voit & DeLaney, 2004), and pain management related to painful medical procedures and conditions (Askay et al., 2007; Lioffi et al., 2005; Smith et al., 1996). However, researchers have contended that clinical practice and related outcomes of hypnosis are rather understudied in the literature, and overlooked as a useful tool in mainstream practice (Kirsch et al., 1993; Lynn et al., 2000; Vandenberg, 2005; Wadden, 1982). Potential influences of this phenomenon may be grounded in several different areas. In the research community, the practice origins of hypnosis, which were not founded in scientific theory, may have contributed to an unstable foundation (Upshaw, 2006). The constant theoretical debate that continues today over what, why, and how hypnosis occurs also appears to have contributed to the mystery of the practice (Sarbin & Coe, 1979). However, within general American culture, misconceptions based on media depictions and the entertainment industry appear to have contributed to its negative portrayal (Barrett, 2006; Grindstaff & Fisher, 2006; Lynn et al., 2000; Upshaw, 2006; Wagstaff, 2008).

Stage hypnosis. Hypnosis has been negatively represented as a mind-control mechanism by the media and through stage performances (Grindstaff & Fisher, 2006; Lynn et al., 2000; Wagstaff, 2008). For many individuals, the word hypnosis conjures up images of a magician waving a pocket watch in front of an unsuspecting stage volunteer, and commanding them to bark like a dog (Grindstaff & Fisher, 2006). Stage entertainers with limited training in hypnosis tend to promote its stereotypes by not providing informed consent, the opportunity to stop the hypnosis as desired, nor monitor for

negative effects, such as extreme embarrassment or feelings of helplessness, after its conclusion (Lynn et al., 2000). Stage hypnotists tend to exploit the cultural misconceptions of hypnosis, such as the fear of being controlled, because it increases the entertainment value of their acts (Lynn et al., 2000). General audiences of a hypnosis performance observe the hypnotist giving direct suggestions (which are often meant to be foolish and funny) to the volunteers, and in turn develop a belief that hypnosis makes people lose control of their inhibitions, and perform all commands by the entertainer. What is left out of this equation is that stage hypnotists often screen the volunteers looking for those who are cooperative and may naturally have lower inhibitions (American Society of Clinical Hypnosis, n.d.b). Gruzelier (2000) notes that due to the practices of stage hypnotists, several countries have made efforts to require accreditation of hypnosis practitioners, and some have even tried to ban stage hypnosis altogether.

The APA defines hypnosis as a tool for therapeutic treatment that should only be used by professionals who have been properly trained and credentialed in their field and in the process of hypnosis (Council et al., 2000). Unlike stage hypnotists, professional practitioners develop rapport with their clients, weigh the pros and cons of using hypnosis, ensure informed consent, and develop the hypnosis process based on the treatment goals of the client (Lynn et al., 2000).

The media and hypnosis. The media portrayal of hypnosis in books, film, and television have facilitated the stereotypes of hypnosis and fueled the fears of culture. Films have portrayed individuals being hypnotized into committing crimes, harming themselves or others, dramatically increasing natural abilities, obtaining supernatural powers, seducing woman, recovering lost memories, or regressing to past lives (Barrett,

2006). Upshaw (2006) suggests that several books written in the 1950s, during the surge of research and establishment of professional associations on hypnosis, may have also impacted the collective psyche of the culture. *The Manchurian Candidate*, by Richard Condon written in 1959 and later made into film, portrayed an American soldier being brainwashed by communist assassins through the use of hypnosis. Fears surrounding brainwashing were at their peak during this time given the threat of the cold war (Upshaw, 2006). While no connection between hypnosis and brainwashing exists, Upshaw (2006) notes, “The truth is never as interesting as fiction” (p. 119). For entertainment value, the media has portrayed hypnosis in a mostly negative fashion, which has influenced public perceptions and fears about the process.

Mainstream beliefs about hypnosis. The practices of stage hypnosis and the exaggerations rendered in the media encourage a negative view of hypnosis. Some of these include, beliefs that people who are hypnotized lose control, can be forced to say or do things they wouldn't otherwise, may feel as though they've been drugged, and will not remember what happens while under hypnosis (American Society of Clinical Hypnosis, n.d.b; Kirsch et al., 1993; Wagstaff, 2008). Additionally, some mainstream beliefs about hypnosis are that only weak-willed people can be hypnotized, hypnosis can force people to tell the truth, and hidden memories can be easily unlocked through the process (American Society of Clinical Hypnosis, n.d.b; Kirsch et al., 1993; Knight, 1991; Wagstaff, 2008).

Contrary to these beliefs, the client is ultimately in control of the hypnosis process, will not perform any behaviors or reveal any information that they do not want, and most will remember everything that occurs during the process (American Society of

Clinical Hypnosis, n.d.b). The definition of hypnosis by the APA additionally states that people do not experience memory loss nor does the process force any particular experiences (Council et al., 2000). Kirsch et al. (1993) equates the question of whether or not a person will *come out of* hypnosis to a question of whether or not they will *stop relaxing*. This statement emphasizes the participant's ultimate control over the course of hypnosis with the practitioner serving as the facilitator, not the commander, of the process (American Society of Clinical Hypnosis, n.d.b).

Hypnosis and its Additional Challenges in the Scientific Community

Pseudo-Memories. Suggestibility, one of the benefits of the mind during hypnosis, has also manifested problems in the realm of memory retrieval (Cowles, 1998). During the 1980s, the scientific community began questioning the validity of using hypnosis to recall and refresh eyewitness accounts of criminal behavior (Upshaw, 2006). In 1985, the American Medical Association on Scientific Affairs investigated the reliability of memories recalled during hypnosis, and found that the practice increased the confidence of recalled memories, but not necessarily the accuracy of the event (Kirsch et al., 1993; Upshaw, 2006). These *pseudo-memories*, or memories influenced by imagination, environment, or suggestion can occur in or out of the hypnosis process, and reflects the fallible nature of human memory (Voit & DeLaney, 2004). As a matter of practice, all clients undergoing hypnosis should be made aware of the possible distortions that can occur with any recalled memories that emerge, because of the heightened use of imagination during the process (Kirsch et al., 1993). Upshaw (2006) notes that although the 1985 report by the American Medical Association on Scientific Affairs was not intended to support a legal exclusion or question of validity of all memories recalled

during hypnosis, it did appear to negatively impact the overall reputation of the practice in the therapeutic community.

Recent public media. In recent news, the account of *Sybil*, the 1973 novel by Flora Rheta Schreiber, which sold over 400,000 copies, has been presented as a hoax in the book, *Sybil Exposed* (2011) by Debbi Nathan (Flatow & Nathan, 2011; Strickler, 2011). The book recounts Sybil's experience of uncovering lost memories of horrific childhood abuse, and exposes 16 different personalities while under the influence of heavy narcotics and hypnosis. Shirley Mason (Sybil's real name) was diagnosed with multiple personality disorder otherwise known today as Dissociative Identity Disorder. In the book *Sybil Exposed*, Nathan writes about her research into the therapy notes and taped sessions between Mason and her psychiatrist (Flatow & Nathan, 2011; Strickler, 2011). Nathan ultimately found that Mason appeared to be a highly suggestible woman who was prone to fantasy, and created these personalities based on the suggestions, and what she inferred as the desired outcome of her psychiatrist (Flatow & Nathan, 2011; Strickler, 2011). Several researchers have found that individuals who have experienced trauma are often highly suggestible and prone to dissociation and fantasy as a means of escaping the memories of abuse (Butler, Duran, Jasiukaitis, Koopman, & Spiegel, 1996; Somer, 2002). Regardless of the whether or not Mason experienced early trauma, or if in fact actually had a diagnosable case of Dissociative Identity Disorder, the recount of her psychiatrist's unethical use of hypnosis has most definitely marked another strike against public opinion of its practice.

Ethical Codes and Training in Hypnosis

Gruzelier (2000) proclaims that the fact an individual in the United States can become a stage hypnotist with little to no formal technique or ethical training is of scientific and social concern. In addition, the previous section recounts the potential harm that can befall on clients if ethical guidelines are not followed. In 1969, the APA formed Division 30; a committee dedicated to the investigation and practice of clinical hypnosis (Council et al., 2000). Although the APA's Code of Ethics governs the practices of all psychologists (just as the National Association of Social Workers' Code of Ethics governs the practices of all social workers), the APA does not have a specific code of ethics or conduct regarding hypnosis within Division 30 (Council et al., 2000). In fact, Voit and DeLaney (2004) assert that the APA's Code of Ethics makes very little recommendations at all regarding hypnosis. Historically, the APA has attempted to establish a code of conduct stating that practitioners must not teach hypnosis to individuals who do not have the proper training, licensure, or expertise in the field (Council et al., 2000). However, due to legal concerns, and the pursuit of legislative action by nonprofessional hypnosis groups this code has since been overturned (Council et al., 2000). Voit and DeLaney (2004) recommend that the practice of hypnosis be ethically rooted in the principles of a solid foundation in therapeutic practices, expertise, continuing education, healthy boundaries, informed consent, and agreed upon expectations between the client and the therapist. Practitioners are also encouraged to utilize supervision when incorporating hypnosis into their clinical practice (Snow & Warbet, 2010).

Professional organizations such as The Society for Clinical and Experimental

Hypnosis (SCEH) and the American Society of Clinical Hypnosis (ASCH) are two well-known groups within the field of clinical hypnosis that offer both training and codes of conduct for practice. SCEH (2001) identified four primary practice standards, which state that the therapist must be in good standing with their professional board, must only practice within their area of expertise, must only use hypnosis for the intention of improving an individual's health and wellbeing (not for entertainment purposes), and when advertised the description must be accurately and responsibly described (as cited in Voit & DeLaney, 2004). ASCH code of conduct (2003) also identifies that the therapist's claims regarding hypnosis must be empirically supported (as cited in Voit & DeLaney, 2004).

Both groups require professional licensure and peer-reviewed training in hypnosis for membership into the organization (Snow & Warbet, 2010). In addition, they offer ongoing workshops at varying training levels (American Society of Clinical Hypnosis, 2011; Society for Clinical and Experimental Hypnosis, n.d.). Such workshops routinely include information on the ethical practices of hypnosis, including the importance of informed consent, risk of false memories, and recommendations against the use of hypnosis in the retrieval or confirmation of abuse memories (Lynn, 2001). Ultimately, the integrity of hypnosis is rooted in the professional and ethical practices of the therapeutic community of practitioners (Voit & DeLaney, 2004).

The Use of Complimentary and Alternative Medicine (CAM) in Health Care

CAM represents a broad and diverse group of health care practices, and their accompanying theories and beliefs, which typically fall outside of the present category of *conventional medicine* within Western culture (Grant, Gioia, Benn, & Seabury, 2009;

National Center for Complementary and Alternative Medicine [NCCAM], 2008). In this context, conventional medicine includes those professional practices that require additional education, training, and licensure, such as with physicians, nurses, social workers, and psychologists. *Complementary medicine* is used in conjunction with conventional medicine, and *alternative medicine* is used in place of conventional medicine (NCCAM, 2008). Just a few of the practices that are included in CAM include, acupuncture, massage, yoga, and biofeedback. The use of hypnosis within the clinical setting is also defined as a CAM-related practice (NCCAM, 2008).

The National Health Interview Survey (NHIS), an annual in-person survey of Americans regarding their overall health and illness management practices, gathered CAM-related health information on 23,393 adults and 9,417 children in 2007 (NCCAM, 2008). Of this information, 38.3% of adults (approximately four in 10) and 11.8% of children (approximately one in nine) reported using CAM interventions. This number is up 2.3% for adults since 2002 (such information was not collected on children during the 2002 survey) (NCCAM, 2008). Of those interviewed, most CAM consumers identified as being female (43%), between the ages of 30 – 69, having obtained a masters degree or above education level, and were living 200% or more above the poverty threshold (NCCAM, 2008). Approximately 2.8% of adults interviewed during the 2007 survey reported using CAM for the treatment of anxiety, and 7.3% of parents reported using CAM to treat anxiety or attention-deficit hyper-activity disorder in their children. Of the information gathered, only 561 (.02%) adults reported using hypnosis as a CAM practice. While this number is up slightly from the 2002 survey (505 consumers), it is still relatively small within the practices of CAM in the United States (NCCAM, 2008). It is

unclear how these numbers and percentages related to hypnosis generalize to the rest of the nation.

Factors that Influence the Under-Utilization of CAM

Gatekeepers. Although the use of CAM in the United States appears to be increasing, there are also several factors that may be contributing to its under-utilization within the health care field (NCCAM, 2008). Within the health care field, conventional medicine providers frequently hold the role of the *gatekeeper* of additional treatment referrals (Josefek, 2000). As the gatekeeper, providers determine what treatments are best suited for the patient, and these recommendations then in turn determine what will or will not be covered by the client's insurance (Josefek, 2000). Alternative treatments are often not recommended by conventional medicine providers either due to elitism or, because the provider is unaware of the benefits of alternative treatments (Josefek, 2000). Levine (1994) states that many physicians in the field of conventional medicine question the safety and efficacy of alternative treatments, and therefore, question whether a referral for alternative treatment may be a violation of their Hippocratic oath to "do no harm" (as cited in Josefek, 2000). This concern highlights the high level of importance connected to practitioners performing research on CAM practices based on scientific methods.

Third-party payers. Third-party payers also pose an obstacle in the access of CAM. In regards to treatment authorization, insurance companies are becoming increasingly stringent in their regulation of the length and frequency of treatment, setting, and the form of intervention (Hubble, Duncan, & Miller, 1999). Moreover, they often refuse to pay for services that are not governed by a licensing board claiming the concern

that they have no way of monitoring the practice of CAM practitioners (Josefek, 2000). Insurance companies are also increasing their demand for empirically support practice, otherwise known as evidenced-based treatment, in place of the practitioners subjective report that the treatment they are providing is effective and safe (Hubble et al., 1999). For CAM providers, this demand has brought the duty of defending the theories and treatment approaches through empirically supported research. Ultimately, this practice supports best practices of professionals, provides evidence of safety and effectiveness, can allow for comparative studies against more mainstream interventions, and adds to the body of knowledge of CAM-related interventions (Grant et al., 2009).

CAM Practices and the Social Work Profession

The National Center for Complementary and Alternative Medicine (NCCAM) (2008) describes *integrative medicine* as the combination of conventional medicine and CAM practices that are empirically supported through research. Although many CAM practices have been examined through scientific means, research is needed to continue exploring the safety and effectiveness of various CAM interventions (NCCAM, 2008).

By nature of its practice, the social work field can also be described as integrative. Social work examines the bio-psycho-social-spiritual framework of individuals, and addresses their needs from a holistic perspective (Grant et al., 2009). In the spirit of supporting a proactive approach to health care social workers are responsible for acquiring knowledge on evidence-based practices that allow for an integrative approach to treatment (Grant et al., 2009). In alignment with the social work value of competence, social workers are required to only practice within their area of strength and competency, but are also expected to broaden their knowledge-base as needs arise for their clients

(Mendenhall, 2003). Social work education and training on CAM interventions, such as mind-body practice therapies, can provide social workers with the tools to teach their clients basic coping and stress management techniques (Grant et al., 2009).

Limited Clinical Research and Training on CAM in the Social Work Profession.

Research. Despite the fact that there are numerous supporters of CAM-related practices in the social work field, the available literature appears to be limited. Of the many articles pertaining to CAM practices and clinical hypnosis reviewed for this paper, only a few were published in social work related journals. The remaining articles were published in either psychological or medical journals. This disparity brings up questions of why such a large publication gap exists between professions. Researchers emphasize the importance of strengthening the present body of knowledge regarding psychotherapy outcomes in order to both learn from and contribute to the realm of clinical social work (Thyer, 2007). Further investigation is needed to explore the contributing factors to either the under-utilization or under-publication of CAM-related practices, such as hypnosis.

Training. If social workers are to maintain their commitment to the values of the profession they must provide advocacy for the holistic needs of the client as well as build competency through ongoing education (Grant et al., 2009; Mendenhall, 2003). While graduate level training serve as an excellent vehicle for this type of instruction, most existing social work curricula provide little if any skills training in CAM practices or integrative health care (Grant et al., 2009). By providing this type of training, social workers may become better advocates for preventative and proactive care regarding the holistic needs of clients (Grant et al., 2009). Furthermore, social workers would emerge

from their education foundation with direct practice skills to support interventions, such as mind-body integration. Many practices within CAM also support the healing traditions of various cultural groups throughout the United States. By developing a knowledge base of these practices, social workers may be better able to show cultural sensitivity and collaboration with alternative care providers (Grant et al., 2009). Grant et al. (2009) suggests that the limited amount of empirically supported research in CAM areas may perhaps play a role in the limited depth of CAM in social work curricula (Grant et al., 2009). Further research is needed to explore these factors.

Cautions Associated with CAM Practices in Social Work

While some researchers support graduate-level social work education regarding CAM practices (Grant et al., 2006), others proclaim such practices as illegitimate and ineffective (Thyer, 2007). Thyer (2007) declares that CAM practices such as Reiki, hypnosis, and energy-work should not be included in social work education or practice. The need for evidenced-based practice is cited as the reason why such practices should not be included in the repertoire of teachings on social work interventions (Thyer, 2007). However, well over 30 articles are cited in this paper alone in support of the benefits of the CAM practice of clinical hypnosis. Questions surrounding the apprehensiveness of social workers in the use of interventions, such as hypnosis, remain to be answered.

Reamer (2006) warns that the implementation of various clinical techniques, such as dialectical behavioral therapy, art therapy, or hypnosis without proper training or certification may be potentially harmful to a client's emotional stability. Social worker skills and expertise are crucial in providing competent client care (Reamer, 2006). If a social worker uses an intervention that is grounded in research and theory, such as

hypnosis, but the practitioner is not properly trained or skilled in the intervention they could potentially cause harm to the individual, and legally be charged with malpractice (Reamer, 2006). Although advice such as this promotes a framework for a sound standard of care in social work practice, it may inadvertently prompt social workers to avoid additional training outside of their competency for fear of malpractice charges or potential harm to clients. Further research is needed to explore such possibilities.

Hypnosis and the Social Work Profession

Ultimately, the clinical application of hypnosis as a tool in the social work field appears to lie in the perspective of the practice. If hypnosis is viewed as a means of gaining control over a client and forcing them to engage in embarrassing or harmful practices it is clearly not aligned with the principals of the social work profession (Winsor, 1993). However, if hypnosis is viewed as a client-centered practice that serves to empower clients to access their own internal skills, than it may be a valuable therapeutic tool that has been overlooked in social work literature and practice (Winsor, 1994). Knight (1991) suggests that the practice of clinical hypnosis is aligned with the social work principle of self-determination (National Association of Social Workers, 2008). He notes that the clinical practice of hypnosis can help clients to see the potential resources that they hold within themselves. In addition, the social worker's bio-psycho-social-spiritual perspective places them in a position of identifying and assessing clients that may benefit from its complementary practice in the social work profession (Snow & Warbet, 2010). Considering the surmounting literature on the efficacy of hypnosis as a compliment to therapeutic treatment, it is quite puzzling why it is not more well known,

researched, published, and utilized in the social work community. Understanding the factors surrounding this divergence appears worthy of additional research.

Conceptual Framework

The conceptual framework functions as the foundational principals and ideas that support the research intention and questions. The conceptual framework used for this study is based on the neuro-imaging workings of hypnosis in the brain, and the underlying theories of hypnosis as compared to those in the social work field.

The Neurology of Information Processing and the Connection to Hypnosis

Challenges in understanding what goes on in the brain during hypnosis can create doubts about its usefulness within the scientific community and the general public (Cowles, 1998). New advances in neuro-imaging research have brought light to the gap between science and theory. The human mind is believed to be quite suggestible, and is bombarded on a daily basis with external stimuli that interacts with memories of past experiences, interpersonal relationships, and internal beliefs (Cowles, 1998). The factors determining our reaction to these stimuli are based on a combination of our conscious and unconscious memories, which can be outside of our awareness. An individual's perception of an object or experience is built upon a plethora of similar experiences from our past (Cowles, 1998). For example, if an individual felt the emotion of fear while involved in a car crash on a bridge, the feeling of fear may then become associated with either the general image of cars or bridges.

The field of neuroscience explains that the mind has a series of feedback circuits that process sensory information (Blakeslee, 2005). Information can be processed from the *bottom-up*, whereas the eyes view the shape of an object, which is turned into a

pattern and sent to the visual cortex of the brain. The pattern is then sent to a higher level of processing where the color is recognized, and finally the identity of the object (Blakeslee, 2005). However, research states that there are ten times more feedback circuits dedicated to sending information down than there are sending information up (Blakeslee, 2005). This manner of *top-down processing* (Blakeslee, 2005; Raz, Fan, & Posner, 2005) can account for the individual's fear reaction to being in a car or on a bridge after experiencing a car accident. The brain is sending warning signals down to the body based on previously stored information.

Research has tested the effects of top-down processing with hypnosis (Raz, Moreno-Iniguez, Martin, & Zhu, 2006). In the area of information processing, reading is considered automatic. For example, for those individuals who are proficient in a language it is difficult to quickly identify the color green if it is written as the word "red" (Raz et al., 2006). The top-down processing of the brain reads the word "red" first, and sees the color green second. This phenomenon is referred to as the *Stroop Effect*, and prompts people to have a slowed reaction to identifying the color (Blakeslee, 2005; Raz et al., 2006). However, when highly hypnotizable subjects are hypnotized and given the suggestion of seeing the words as meaningless symbols they are able to quickly and easily identify the color of the word, and the Stroop Effect is reduced or eliminated (Blakeslee, 2005; Raz et al., 2006). Through the process of hypnosis, an individual can therefore bypass automatic responses, consciousness filters, or preconceived concepts and directly access the unconscious mind to replace or alter previous perceptions (Cowles, 1998).

Framework of Hypnosis

The framework of hypnosis rests firmly in the psychoanalytic and psychodynamic perspectives. The basis of psychoanalytic theory assumes that human motivation aims to satisfy unconscious internal drives, and utilizes defenses as a way of protective itself from unconscious memories that may be painful in some way (Cowles, 1998; Hutchinson, 2008). The *unconscious mind* is defined as the part of the self that holds information outside of our awareness, yet still influences our behaviors (Hutchinson, 2008). The *ego* serves as part of a person's personality that negotiates behaviors and reactions based on internal and external influences (Hutchinson, 2008).

The psychodynamic perspective is concerned with the needs, drives, and emotionally motivating factors of human behavior, however, also takes into account the adaptive capabilities of human nature, and the effects of the person's environment (Hutchinson, 2008). Psychological problems are seen as stemming from a conflict between the needs and desires of the person and the demands of their environment. Defenses such as, anger, repression, denial, and rationalization are used to protect the conscious mind from experiencing uncomfortable or painful material from the unconscious mind (Hutchinson, 2008). Theories such as attachment theory, object relations theory, and self psychology are modern psychodynamic perspectives based on the founding ideas of Freud, including the structural model of the id, ego, and superego, and the topographic model of the conscious and unconscious mind (Hutchinson, 2008).

As earlier noted, Sigmund Freud, the founder of psychoanalysis, was said to have developed his theories of the conscious and unconscious mind based on his training and practice in hypnosis (Kirsch et al., 1993, Upshaw, 2006). Therefore, many of today's

concepts regarding hypnosis, such as accessing the unconscious through trance, reflect its origins in the psychoanalytic and psychodynamic perspectives (Cowles, 1998). The Neurodissociation Theory (as cited in Kirsch et al., 1993) discussed earlier in this paper reflects the concepts of consciousness, unconsciousness, and dissociation, which are all terms that stem from the psychoanalytic and psychodynamic perspective. While the theories of psychoanalysis and psychodynamics are taught within graduate-level social work training they are not necessarily considered founding theories in the profession. This disconnect between the psychoanalytic foundation of hypnosis and the founding principles of social work may perhaps play in role in the under-utilization of hypnosis in the social work field. The following information will elaborate on some of the established perspectives of social work that form the framework for the profession.

Framework of Social Work

According to the National Association of Social Work (NASW) (n.d.), “Professional social workers assist individuals, groups, or communities to restore or enhance their capacity for social functioning, while creating societal conditions favorable to their goals. The practice of social work requires knowledge of human development and behavior, of social, economic and cultural institutions, and of the interaction of all these factors” (para. 1). As earlier noted, by its definition, the field of social work is integrative, and utilizes a bio-psycho-social-spiritual perspective of the person (Grant et al., 2009). A few of the ethical values included in the NASW Code of Ethics (2008) includes dignity and worth of the person, social justice, and integrity. These values reflect the *strengths-based perspective* of social work, which focuses on the capabilities and abilities of the person from an empowerment approach (Miley, O’melia, & DuBois,

2007). This perspective is aligned with the social work value of dignity and worth of the person. Additionally, an empowerment-based social work practice includes the *ecosystems perspective* or *person-in-environment perspective* (Miley et al., 2007). This perspective views problems and challenges in the client's life from varying lenses, including the family system (micro), neighborhood or workplace (mezzo), and the community at large (Miley et al., 2007). These environmental subsystems are all incorporated into the challenges that a client or group of people may experience, and social workers advocate on behalf of clients in establishing social justice.

Hypnosis & Social Work Practice

Again, while the micro-level, clinical perspective of social work does utilize theory from the psychodynamic approach it appears to be just one perspective from which social workers strive to meet the needs of their clients. Additionally, some social work literature speaks to the concern that the terminology and pathology associated with the psychodynamic perspective is a slippery slope leading to demeaning labels that fuel stereotypes and institutional oppression (Miley et al., 2007). However, as noted earlier in this paper, social work literature on the subject of hypnosis regards the practice as aligned with the social work profession noting its client-centeredness, empowerment approach, and integrative use as a complimentary practice (Knight, 1991; Snow & Warbet, 2010; Winsor, 1994). To some degree, it is questionable whether the psychodynamic origins of hypnosis may be a conflicting aspect in the utilization of hypnosis in clinical social work practice. The limited research in the social work field on this subject supports the investigation of factors surrounding the perspective, stereotypes and misconceptions, and utilization of hypnosis by social workers in the profession.

Research Question

The combination of misconceptions, limited application in social work as a therapeutic tool, and limited social work research provides support for further examination on the utilization of hypnosis within the social work profession. Therefore, this research study asks the question: What are the factors surrounding the underutilization of hypnosis as a therapeutic tool in clinical social work practice?

Methods

Sample Overview

This study utilized a *qualitative approach* to investigating the research question. As a reminder, qualitative research uses a *nonpositivist* or *interpretive approach* by obtaining a subjective understanding of a topic based on the experiences and perspectives of the individuals themselves (Monette, Sullivan, & DeJong, 2008). Qualitative data is gathered in the form of words or narratives through means such as one-on-one interviews (Monette et al., 2008).

For the purposes of this qualitative study, a nonprobability *snowball* sample of seven Licensed Independent Clinical Social Workers (LICSW) in the mental health field was gathered. Snowball sampling begins with a few referral sources or respondents who may then refer other respondents to the study (Monette et al., 2008). The sample size builds upon previous referral sources, and is useful for subcultures that may interact with each other frequently (Monette et al., 2008). Through this definition, clinicians who use hypnosis in their clinical practice can be seen as a small subculture, and therefore, served as a solid referral source for other practicing clinicians in the field.

Respondent Criteria

Qualitative data was gathered through one-on-one interviews on the topic of the under-utilization of clinical hypnosis in the social work field. The researcher interviewed four LICSW respondents who practice clinical hypnosis, and three LICSW respondents who do not practice clinical hypnosis. The purpose of sampling from these two populations was to gain perspective from inside and outside the sub-culture on factors, which may shed light on the question of why hypnosis is under-utilized as a tool in therapeutic treatment. The main respondent sample target for this study was LICSW respondents who work therapeutically with clients in an outpatient clinic or private practice setting.

Respondents who used hypnosis in their practice were considered for the study if: they were clinically board-licensed, were in good standing with the professional board of social work, practiced within one of the identified settings, and had completed at least 20-hours of training on clinical hypnosis through a professional organization such as, The Society for Clinical and Experimental Hypnosis (SCEH), The American Society of Clinical Hypnosis (ASCH), The International Society of Hypnosis, Minnesota Society of Clinical Hypnosis, or a similar organization. Of note, both the SCEH and ASCH require at least 20-hours of approved introductory training in hypnosis to be considered for membership into the organizations (ASCH, n.d.c; SCEH, n.d.). Respondents who did not practice clinical hypnosis were considered for this study if: they were clinically board-licensed, were in good standing with the professional board of social work, and practiced within one of the identified settings.

Recruitment & Research Consent

The researcher of this study contacted current professional associates (fellow graduate social work students, Licensed Graduate Social Workers, and Licensed Independent Social Workers) by email, phone, or in-person, and asked them to refer potential respondents to the study who met the established criteria. A brief summary on the purpose of the study was provided electronically or in hard copy format (See Appendix A). Potential respondents who showed an interest in participating in the study were asked to contact this researcher by email or phone. An electronic or hard copy form of the research consent document was then provided to the potential respondents for their review (See Appendix B). If the potential respondents reviewed and concurred with the information provided in the consent form a one-on-one interview location, date, and time was scheduled. Satisfaction of the established respondent criteria was confirmed with the respondents prior to the interview.

Study Respondents

For the purposes of this qualitative study seven clinicians were interviewed on the subject of clinical hypnosis. As noted, four of the respondents were trained and regularly used hypnosis in their clinical practice setting, and three respondents were not trained nor used hypnosis in their therapeutic practice. All of the respondents interviewed had at least an MSW degree and all were licensed as LICSW practitioners. Three of the respondents had undergraduate degrees in social work. Additionally, four respondents had more than one graduate degree, and two of these clinicians had both a masters degree in social work and psychology.

Years in practice. The number of years in clinical practice after obtaining an MSW degree ranged from three years to 33 years, respectively. The average number of years in practice amongst the seven clinicians was 19 years.

Employment. All of the respondents interviewed practiced clinical social work, and were employed as therapists in their employment setting. Respondents worked with a range of clients including adults, children, adolescents, families, and couples. Interestingly, three of the respondents had either a historical or current clinical practice involvement with oncology patients. Respondents were employed in either outpatient clinics or individual or collaborative (more than one clinician) private practice clinics. One respondent was employed in a rural area of Minnesota. Another respondent worked in a medical model setting with physicians and nurses as well.

Hypnosis use and training. Four of the respondents interviewed practiced clinical hypnosis regularly in their employment setting with clients. Client populations included both children and adults. Clinician training, practice, and consultation included five, 15, 20, and 25 years, respectively.

Protection of Human Subjects

For the protection of human subjects in this study a consent form (Appendix B) was used. The consent form was reviewed by this study's research chair, Dr. Sarah Ferguson PhD, the investigator's research committee, Beverly Caruso MSW LICSW and Bruce Eisenmenger MA LP, and was approved by the St. Catherine University Institutional Review Board (IRB). The consent form consisted of information on the purpose of the study, including the research question, procedures, risks and benefits, steps to protect the confidentiality of the respondents, volunteer nature of the interview, ability

to withdraw or stop at any time, and contact information for the St. Catherine University IRB, faculty advisor and research chair, Dr. Sarah Ferguson PhD, and this researcher.

Within the consent form, participants were reminded that their participation in the study was completely voluntary, and they could stop the interview at any time without penalty. None of the respondents chose to withdraw during the interview; however, if they would have their information would not have been used in the data analysis. In addition, the study had no risks or direct benefits of participation.

During transcription of the interview, the researcher omitted any personally identifying information that was shared in order to protect the respondents' confidentiality. Research records of this study were kept in a locked file drawer at the home of the researcher. In addition, the audio files and electronic copies of the transcripts were kept in a password-protected file on the researcher's computer. Qualitative data from the transcripts is presented in the "Findings" and "Discussion" section of this research paper, and will also be presented during a clinical research presentation in May 2012. The audio recordings and transcripts of respondent interviews will be destroyed by June 1, 2012.

Data Collection

The collection of data was obtained during a semi-structured interview containing 12-17 open-ended questions (see Appendix C), which were reviewed by Dr. Sarah Ferguson PhD and the investigator's research committee for content validity, and also were approved by the St. Catherine IRB prior to the interviews. The interview questions were developed by the researcher, and were based on the study's literature review on clinical hypnosis. The interview questions focused on respondents' graduate training,

theoretical framework, clinical practices, and opinion regarding the use of hypnosis. In addition, the respondent's use of hypnosis in clinical practice, if any, was explored. Professional and general population beliefs regarding hypnosis, and its alignment with the social work profession were also addressed. As recommended in Berg (2009), the questions began with more demographic information and narrowed to more specific information regarding hypnosis as the interview continued. The interviews took place over the course of approximately 25-50 minutes, and were audio recorded as an MP3 file on Apple's MacBook Pro laptop. The entirety of each interview was transcribed for this study's data analysis purposes. Again, no personally identifying information of the respondents was included in the transcripts or clinical research presentation.

Data Analysis

Again, the aim of this study was to explore the question: What are the factors surrounding the under-utilization of hypnosis as a therapeutic tool in clinical social work practice? Data was collected using the qualitative method of a semi-structured audio-recorded interview of four LICSWs who used hypnosis in their clinical practice, and three who did not. The data was evaluated using the qualitative analysis method of *content analysis*. According to Berg (2009), content analysis is an inductive, systematic means of evaluating the raw data, to look for repeated subjects or ideas that emerge from the information. The method construes information from the details of the raw data, and expands to more broad-based themes and theories.

The transcribed interviews were thoroughly reviewed for *codes* and *themes*. Codes are repeated words or phrases identified within the data (Berg, 2009). Once three or more codes are identified, a theme, or summarizing word or phrase, is formed (Berg,

2009). *Open coding* was used to identify codes and themes in the transcripts. Open coding is a process of carefully reviewing and coding each line of data in the transcript (Berg, 2009). Themes were constructed based on the respondents' direct quotes. *Memos*, or preliminary theories regarding the data, were identified in the margins of the transcripts. Similarities and differences within the data were identified during the process.

Findings

Analysis of the qualitative data found seven major themes including: clinical social work practice with clients, respondent training and knowledge of clinical hypnosis, the healing and empowering benefits of hypnosis, the misconceptions of hypnosis and the related impact in social work, contributing factors to the under-utilization of hypnosis in social work practice, the alignment of hypnosis with the social work profession and code of ethics, and recommendations for hypnosis education. Several major themes are also accompanied by two to four sub-themes that unite to support the overarching foundation of each segment.

Clinical Social Work Practice With Clients

The first theme found was drawn from the codes regarding clinical social work practice with clients. This theme was pulled from the coded transcripts of clinicians who use hypnosis in their practice and those who do not. This theme included the sub-themes of clinician theoretical framework for practice and clinician opinion regarding evidenced-based practices.

Theoretical framework. Respondents identified a range of frameworks and interventions for practice including, Crisis Counseling, Systems Theory, Psychodynamic and Psychoanalytic Theory, Developmental Perspective, Historical Perspective,

Interpersonal Approach, Buddhist Psychology (also described as compassion and understanding), Person-In-Environment, Bio-Psycho-Social-Spiritual Perspective, Mindfulness Skills, and Cognitive-Behavioral techniques. Additionally, several individuals identified an Integrative or Holistic Perspective for practice.

An eclectic approach. A few respondents described their framework and approach for practice as “eclectic,” and noted that theory does not always lend itself to practice. These respondents described using an array of approaches as a means of meeting the multi-faceted needs of their clients. In this manner, respondents described that the direction and orientation of the client tends to guide their practice. In an example of an eclectic approach, one respondent described, “*After so long you get used to finding things that work, and just bringing that in, as opposed to having a structure and pushing people into it.*”

Use of self. Several respondents identified “use of self” as the most important guide in their practice. Respondents described use of self as the “*biggest caveat to success*” in clinical practice, and noted that the establishment of trust in the relationship is pivotal for a client’s progress in treatment. As one respondent identified, “*For any therapist out there I think that is one of the biggest things to remember. Therapeutic use of self has a tremendous impact on clients.*”

Graduate training. Overall, respondents tended to say that their graduate training established their theoretical base and basic skills for practice. However, since then, their perspectives and approaches have expanded through further professional trainings and clinical experiences above what was taught in their graduate education.

Evidenced-based practice. When asked about the term “evidenced-based,” and its related meaning respondents described its practices as research-driven, outcome-based, and standardized with measurable effects. Evidenced-based outcomes were described in terms of being the “*success or failure of a particular strategy, medication, or intervention.*” Some respondents stated that they frequently incorporate evidenced-based research data into their psycho-education with clients while others stated that they tend to only track and reference the therapeutic success of their own work.

Cognitive-behavioral therapy. Overall, the vast majority of respondents identified Cognitive-Behavioral Therapy (CBT) and its related interventions as evidenced-based practices. Respondents referenced their knowledge of the published and empirically based results of CBT in their answers. Only one respondent (who uses hypnosis in practice) identified hypnosis as an evidenced-based intervention.

Respondent Training and Knowledge of Clinical Hypnosis

The second theme identified within the data was respondent training and knowledge of clinical hypnosis. This theme was interpreted from the coded transcripts of all the interviewed social workers, and was divided based on whether or not the respondent used hypnosis in clinical practice.

Respondents who use clinical hypnosis in social work practice. The following information was drawn from the codes of clinical social workers who use hypnosis in therapeutic practice. Two of these respondents identified that someone they knew who was trained and used clinical hypnosis with clients introduced them to the intervention. The other two respondents reported becoming interested in hypnosis during a training

experience. As earlier noted, respondent training and practice in hypnosis ranged from five years to 25-plus years of continuing education, application, and consultation.

Several respondents spoke to the level of continuing education and commitment needed to become proficient in using clinical hypnosis in a therapeutic practice. “*One weekend seminar*” was described as not being sufficient in order to develop a competent practice that is tailored to the clinician’s style and client base. Respondents recommended continued training in order to strengthen clinical skills and receive feedback from other practicing clinicians. In fact, one respondent who has been training and practicing hypnosis for five years described himself or herself as, “*middle of the road.*” In addition, respondents spoke positively about their training experiences in Minnesota, and noted there was a good deal of emphasis on application and follow-up training.

Respondents who do not use clinical hypnosis in social work practice.

Respondents who do not use hypnosis in their practice spoke to their general knowledge and any related experiences with hypnosis, including known uses for the intervention. As a whole, respondents who did not use hypnosis in clinical practice noted that they knew very little about its clinical uses, but did emphasize the need for in-depth training. One respondent referenced it being discussed during graduate school as a beneficial therapy tool, and another reported a history of casually knowing a social worker who used it in practice. A few respondents referenced their knowledge of hypnosis in terms of being “*used for fun.*” In addition, a few respondents also mentioned the concern about hypnosis and false memories. Of note, none of the respondents who use hypnosis in their practice addressed this concern during the interviews.

Related experiences with hypnosis. One respondent who did not use hypnosis in practice described two generally negative related experiences. In one circumstance, the respondent described being on stage during a work party, being uncomfortable with the performer's suggestions, and consequently getting off stage. The respondent notes, "*All I know is that I had enough presence of mind and I knew I was not comfortable and I was aware of the suggestions that I walked off the stage.*" In an earlier experience during adolescence, the respondent described being sent to a hypnotist by a family member with the desired outcome of losing weight. During the hypnosis process, the respondent described, "*some kinds of inappropriate touch and inappropriate things that were done under the guise of hypnosis.*" The respondent noted that this experience would not deter him or her from referring clients to hypnosis as appropriate, but did conjure questions regarding the ethical training of this practitioner.

Knowledge of uses with hypnosis. Respondents identified a narrow range of knowledge regarding the uses of hypnosis including, pain and anxiety management in hospital settings, smoking cessation, trauma, general wellness, skills acquisition, and visualization of a more empowered self. Overall, the use of hypnosis for smoking cessation was the most commonly identified response.

Concern of false memories. Respondents who do not use hypnosis in practice identified concerns regarding the possibility of false memories during the process. As one respondent described, "*to discover or dig out a traumatic memory that they're not sure is there.*" The concern mostly existed around the influence of suggestion in recalling memories of sexual abuse. An undertone within the responses included the worry of "*making somebody remember,*" and media related stories of memories being "*planted*"

during therapy sessions. Again, respondents who use hypnosis in their practice did not address this concern.

The Healing and Empowering Benefits of Hypnosis

The third theme of the healing and empowering benefits of hypnosis was drawn from the transcripts of respondents who use hypnosis in therapeutic practice.

Respondents who use clinical hypnosis endorsed multiple client concerns for which they use hypnosis as an intervention. Throughout the interviews, respondents used words such as “*transformational*” to describe the use and healing power of hypnosis. In addition, respondents spoke to the benefits of using hypnosis as a therapeutic intervention, including the power of the unconscious mind. Therefore, the healing benefit of hypnosis was a strong sub-theme.

Another major sub-theme highlighted throughout all of the coded transcripts by respondents who use hypnosis was also the client-empowerment aspect of the intervention. Respondents spoke to their role as a facilitator in assisting clients with drawing upon their own internal resources.

Hypnosis as a therapeutically healing intervention. Respondents who use hypnosis spoke to the healing aspects of the intervention through multiple means. The theoretical understanding of hypnosis as an intervention, which accesses the lower regions of the brain and bypasses the cognitive schemas was discussed as a way to directly address problematic concerns. Combining the conscious mind, unconscious mind, and the body were described as offering the greatest amount of “*power*” and “*empowerment*” to the hypnosis recipient. As one respondent notes, “*We’re changing the neuro-pathway experience while no longer stimulating the amygdala reactivity so they’re*

having a brand new experience of that (traumatic) memory that was triggering them, but now they're not triggered."

Respondents also described using hypnosis as an intervention for numerous mental and physical health concerns. Its uses included, pain and anxiety management for children in a hospital setting, somatic complaints (including stomach aches, headaches, pain, and migraine headaches), anxiety (including social and separation anxiety), sleep, and ego strengthening. In reference to a separation anxiety problem, one respondent recalled, *"A young man on his way to college who had separation anxiety we did some hypnosis and he was like, 'I'm done, I'm fine, I'm done. This was the greatest thing ever! And I'm going to be fine!'"* Additionally, in a dramatic recovery from troubling symptoms, another respondent described, *"I've had people come for panic attacks, 27 years of panic attacks gone in one session. 40 minutes. They came back one more time for a completely separate issue."* Overall, respondents described the use of hypnosis as *"highly effective"* and *"fruitful"* in clinical social work practice.

The client-empowering aspects of hypnosis. As identified, the client-empowering aspects of hypnosis were shared throughout the interviews with respondents who use hypnosis in their therapeutic practice. Respondents described providing clients with hypnotic interventions and tools to facilitate client empowerment and a sense of control. As one respondent described, *"It (hypnosis) gives them a sense of control...So they're showing themselves, 'I don't have to sit in that place of discomfort. I do have options.'"* Respondents described that using hypnosis in clinical practice helps clients to believe in themselves and their ability to change through access to their own internal resources. Hypnosis was described helping recipients to uncover and discover resources

within themselves that can help them to “*self-calm*,” “*self-regulate*,” and access “*all the resources within them to get well*.” Additional phrases such as, “*You’re no longer a victim, you’re in charge now*,” and “*We usually know what the answers are, but we don’t always have access to it*,” were used to describe the experience of empowerment, which appears to be inherent in the clinical intervention. Respondents described the role of the therapist in this practice as a “*guide*,” in the process of healing.

The Misconceptions of Hypnosis and the Related Impact in Social Work

The fourth and largest theme drawn from the transcripts was the misconceptions related to hypnosis. Responses regarding the inaccurate images and behaviors portrayed through stage hypnosis and the media were woven throughout all of the qualitative interviews. Respondents spoke to their opinions regarding general public and health care provider perspectives of hypnosis, and how they manage the misconceptions in their practice. Hypnosis was also discussed as being on a continuum with mindfulness and relaxation interventions. Similarities and differences between these practices were addressed as well as the opinion that mindfulness practices are presently more accepted than hypnosis practices. Given the size of this theme, it is divided into the four sub-themes of: general population perceptions, provider perceptions, management of misconceptions, and finally the similarities and differences between hypnosis and mindfulness practices.

General population perceptions. Respondents referenced generally negative assumptions from the perspective of the general public, which overall, were completely opposite from the empowering aspect noted by hypnosis respondents. These codes were drawn from the interviews of both hypnosis respondents and non-hypnosis respondents.

References to stage hypnosis were the most commonly noted response from the general public. Images of stage hypnosis, including high school performances, television programs, the swinging pocket watch, and the “*whirly eyeballs*” in cartoons were cited in connection to the entertainment world. References to hypnosis being “*magic*” were also recurrent responses.

Fears surrounding the therapist controlling the client in some manner, and forcing them to engage in silly, embarrassing, or truth-telling behaviors were frequently noted. The most repeatedly cited fear appeared to be the concern of the hypnotist controlling the recipients’ mind in some fashion. A few respondents also noted that clients have been told by their religious leaders to avoid hypnosis, because of its connection to “*Satan*” and “*devil worship*.” As one respondent described,

It’s mind control. It’s devil worship. It’s charlatanistic and you back like a chicken, and you’re not in control at all. And what if you get stuck there, and what if they make you do stupid stuff, or unethical things, like take your clothes off, and run around or give me your Visa card, or write checks. Those are the ones I typically hear.

Additionally, another respondent noted the unrealistic expectations that are sometimes placed on hypnosis in relation to losing weight or quitting smoking without having to put any effort into the change. In general, respondents stated that they felt that the negative and controlling general population beliefs regarding hypnosis greatly impacted the acceptance and use of the intervention in clinical practice.

Similarities between general population and respondent misconceptions. To a lesser degree, some respondents who did not use hypnosis in their therapeutic practice

appeared to also share some concerns about hypnosis that were similar to the general population perspectives. These respondents cited fears of “*not wanting to overstep my boundary or be unethical*” as reasons why they have not been interested in exploring its use in clinical practice. Furthermore, concerns that the client is not fully aware of what is occurring while under hypnosis were also cited. As one respondent identified,

Under hypnosis a person is not (emphasis), and maybe I’m wrong about this, but a person is not (emphasis) aware of everything that they are saying or doing. You know, I mean that’s the purpose of it is to get at those unconscious things that a person is not consciously aware of. And sometimes I’m sure that can be helpful, and sometimes I think it’s potentially harmful.

Provider perceptions. Respondents also spoke to their opinion of how the community of mental health and medical providers perceives the practice of hypnosis. Hypnosis respondents tended to carry the belief that other providers who were not educated or trained in hypnosis may view it on a spectrum from generally positive to generally negative. Some respondents cited experiences of other providers perceiving them as “*crazy*” or “*from California,*” and tended to generally be skeptical or surprised when they learned of the respondents’ practice of hypnosis. Overall, respondents described that reactions from other professionals can often range from “*fascinated*” to “*dismissive.*” Education regarding hypnosis and how it is used within the clinical setting was the largest factor noted in its acceptance or rejection by other professionals.

Non-hypnosis practitioners. Respondents who did not use hypnosis identified a general sense of receptivity to the practice and stated that other providers’ receptivity would depend on their openness to novel concepts. Non-hypnosis practitioners stated

that, “*clinicians and providers may be a little skeptical, but not as fearful as the general public.*” These respondents described that providers typically have a wider view of how interventions may be used in clinical practice over those within the general population. One respondent wondered if hypnosis would not be taken seriously by other providers or “*might see it as not being a real part of therapy.*” By and large, these respondents noted provider education as a pivotal factor in the acceptance of the intervention in addition to the providers’ receptivity to alternative mental health interventions.

Management of misconceptions. How respondents manage the misconceptions of hypnosis differed throughout the transcripts. Some clinicians were more inclined to provide education about the clinical practice of hypnosis in an effort to dispel the misconceptions. Others described a practice of avoiding the use of words associated with hypnosis, because the powerful misconceptions deterred clients from accepting the intervention.

Teaching clients about hypnosis. Some respondents who use hypnosis in clinical practice described teaching clients about the intervention, including history, procedure, benefits, and empowering aspects. In an example of this, one respondent stated, “*The fact is you’re always conscious. You’re always able to take yourself out of it if you’d like. You’re always in control. And you’ll experience that when we do it.*” Respondents described inquiring about the client’s knowledge and images of hypnosis when they introduced the intervention in session in order to clarify any preconceived misconceptions. Teaching clients about the practices of hypnosis was repeatedly cited as a beneficial means of decreasing the power of its related negative associations. In regards to ethical practices in clinical care, one respondent stated,

I say for the appropriately trained mental health care provider who uses hypnosis it is unbelievably unethical to do anything that is against the client's will in the use of imagery or hypnosis or trance states. And it will never happen in this office.

Avoiding the word hypnosis and its related terminology. A few respondents described using hypnosis with clients, but avoiding the word “*hypnosis*” and its related terminology. Factors such as the influences of the general population misconceptions and images were noted as reasons for evading these words and phrases. Respondents referred to the large amount of time and preparation needed in session to overcome these misconceptions, and therefore, stated it was easier to just avoid the phrase when using the intervention with clients. Words and phrases such as, “*off-putting*,” “*red flag*,” and “*client resistance*” were identified in relation to client's responses to hypnosis terminology. The word “*trance*” was described as being connected to the misconception of hypnosis as mind control, and was generally avoided. Instead of using the word “*hypnosis*” and its related language, these respondents stated that they typically call the intervention “*relaxation*,” “*mindfulness*,” or “*being in the zone*.” These terms were described as being generally more accepted and not having the same misconceptions associated with them. One respondent also questioned how other providers may perceive clinicians who are more forthright about their use of hypnosis, and stated, “*I'm always impressed by colleagues who put 'hypnosis' on their cards...I wonder what the impact is when their card gets passed.*”

Similarities and differences between hypnosis and mindfulness practices.

Hypnosis was also described in terms of being on a continuum with other relaxation interventions. Hypnosis respondents identified similarities between hypnosis and

mindfulness or meditation, such as use of the body and breath to facilitate a relaxed state. Parallels between the trance states and transformational experiences of hypnosis and meditation were also noted. Additionally, respondents discussed their opinion regarding the general acceptance of mindfulness and meditation practices by providers and the public. Mindfulness practices were described as currently being “*trendy*” in contrast to the negative images and “*bad wrap*” associated with hypnosis. Individuals who use hypnosis in their clinical practice also generally described using mindfulness and meditation practices as well.

Differences between mindfulness and hypnosis. As discussed, several parallels were drawn between the interventions of mindfulness and hypnosis. However, hypnosis appeared to be distinguished from other relaxation practices by certain intervention tools used to facilitate trance. Trance in relation to hypnosis was described as a deeper relaxed state in which recipients are more open to suggestion. Hypnosis-related tools such as, “*the dial*” used as self-regulation tool and the practice of self-hypnosis were described as specific to the hypnosis intervention. In addition, interventions such as age regression were also described as only being used in the context of hypnosis.

Contributing Factors to the Under-Utilization of Hypnosis in Social Work Practice

For the fifth theme, respondents identified several factors that may contribute to the under-utilization of hypnosis in social work practice. The sub-themes of graduate education, theories and perspectives of social work, research in the social work profession, and limited hypnosis education and publication serve as the pillars of the overarching theme.

Graduate education. Numerous respondents discussed their opinions regarding graduate education in social work. This included opinions concerning the adequacy of social work training and also responses that hypnosis was not discussed during their graduate training.

Some respondents described that their graduate training was rather overly focused on theory, and therefore, made it difficult to apply their learning to clinical practice. Moreover, they noted that their graduate classes were based around, *“a sense of reviewing and then encouraging people to do a lot of their own readings. The discussions were more philosophical versus the actual kinds of ins and outs of different approaches.”* Two respondents commented on their beliefs that social workers tend not receive a clinical training experience that is as deeply focused on theoretical perspectives and orientations as psychologists. One respondent even went so far as to state, *“Well, I don’t think that social workers are as well trained to do psychotherapy as psychologists are, frankly.”*

In regards to hypnosis, respondents stated that the intervention was generally not discussed during their graduate training, and therefore, may have been *“forgotten about and a little misunderstood.”* Respondents referenced how approaches such as Cognitive-Behavioral Therapy were discussed and taught more in-depth, whereas conversation about hypnosis did not take place possibly leading to the intervention not being as thoroughly understood.

Theories and perspective of social work. Several respondents identified that the theories and perspective of social work may perhaps have an impact on the use of hypnosis in practice. Namely, respondents spoke to the divergence in the profession

between the macro and micro viewpoints. The perspective of Person-In-Environment and the macro lens of the human experience were identified as broad views in social work that may not include specific interventions such as hypnosis. Respondents stated that social workers are often seen more in the roles associated with the macro lens as in foster care, child protection, and case management, and are not always associated with the micro areas of the profession. As one respondent stated,

As a social worker the emphasis is on person-in-environment, and dealing with all the dynamics and not necessarily honing in on one specific specialty...in hypnosis it's very specialized...Psychologists tend to focus on little specialties. They do a lot more testing, for example, they do IQ testing, and different things like that that the clinical social worker doesn't really do. You know, we could go to the training and do it, but that's not generally what you think of when you think of clinical social work. You think of a broader scope rather than the little specifics.

One respondent also questioned if the origins of hypnosis in psychoanalysis may place the intervention “*in the ethers of the past,*” and play a role in its current under-utilization in social work.

Research in the social work profession. Several respondents also spoke to the perspective that research is generally not associated with social work. Factors such as the lack of a solid theoretical base, a primary focus on clinical practice, the time required, lack of pay, and differences in the macro and micro perspectives of the profession were cited as contributing to the lack of research in social work. One respondent stated that if social workers do not have a strong theoretical base, and tend to identify more as

“*eclectic*” than they may not be as determined to engage in research surrounding a specific approach. In addition, respondents who had a dual degree in psychology and social work identified that the encouragement to research, write, publish, and continue doing so throughout their careers was heavily emphasized in their graduate psychology training, but not as much in their social work training. One respondent also questioned the connection between research and the macro and micro perspectives of the profession. The respondent stated,

I don't know if that just goes back to the differences in where the field started from...The micro and the macro and the masters level programs of who chooses to do more of the public policy work versus the clinical. Maybe that kind of splits the profession a little bit in terms of research.

Limited hypnosis education and publication. The final sub-theme concerning the contributing factors of the under-utilization of hypnosis in the social work profession was identified by the respondents as being connected with a limited amount of education and publication on clinical hypnosis. Respondents discussed a lack of visibility regarding hypnosis research, related articles, and a general lack of exposure to the clinical intervention. One respondent recalled that a recent edition of the *Clinical Social Work Journal* was dedicated to integrative therapies, however, none of the articles discussed the use of hypnosis. Respondents stated that social workers might not be aware of their eligibility for training or might not be interested in the level of commitment needed to become proficient in its use. Additionally, respondents who do not use hypnosis in practice noted a general lack of exposure to training opportunities, or even the opportunity to learn about its clinical, evidenced-based practices.

The Alignment of Hypnosis with the Social Work Profession and Code of Ethics

For the sixth theme, respondents who use hypnosis in their therapeutic practice adamantly agreed that hypnosis was aligned with the social work profession and code of ethics. The strengths-based and empowerment aspects of clinical hypnosis were highlighted as the predominant supporting factor. However, respondents who did not use hypnosis in their therapeutic practice were somewhat more cautious in their responses regarding the alignment. These respondents focused on the importance of using hypnosis in an ethical manner to ensure adherence to the code of ethics.

Hypnosis providers. As noted, the respondents who use hypnosis in clinical practice identified that hypnosis was “*truly aligned with the social work profession,*” because of its strengths-based and empowering approach. The implicit focus on the connection to self and wealth of internal resources were specifically identified. Connections between the practices of hypnosis and the social work code of ethics were described as being aligned. For example, one respondent stated, “*The social work ethics and the hypnosis ethics are very corresponding. Using your skills in the best interest of the client. Not forcing people to do things they don’t want to do. You’re respecting their integrity as an individual.*”

Non-hypnosis providers. Again, as noted the providers who do not use hypnosis in clinical practice were more apprehensive in their agreement that hypnosis is aligned with the profession of social work and its related code of ethics. The underlying concern of the non-hypnosis respondents appeared to be the ethical use of hypnosis in practice. Respondents cited caveats and statements of “*if it’s done in a healthy way,*” and “*I don’t think it’s anti-code of ethics (emphasis)*” in response to this question. Sufficient training

and use of informed consent, including the risks and benefits of the intervention were strongly recommended to avoid unintentional harm of the client. As one respondent stated, *“It puts a great amount of responsibility upon the clinician to be absolutely 150% ethical in everything that they do in that context.”*

Recommendations for Hypnosis Education

The final theme addresses the recommendations for education regarding clinical hypnosis. Respondents identified client success stories, graduate-level education, general professional education, and increased hypnosis publication as recommendations. In addition, respondents also spoke to the challenges associated with provider education due to limited funding and professional organization.

Respondents described that one of the best tools for education can be clients sharing positive experiences regarding the therapeutic use of hypnosis. Also, providers who do not use hypnosis recommended seminars and professional-level discussions about how the clinical applications can be distinguished from the entertainment world. At the graduate level, respondents recommended incorporating more education around alternative and integrative psychotherapies, including the beginning conversations about the practice of hypnosis in therapy. One respondent stated,

It could be something that could be incorporated into the educational programs that are training and educating therapists. And if it could be talked about a little more that would be a good setting to get the word out...Even learning about where is it appropriate? What kind of setting would you use it? Where is it useful? Where is it not useful?

Respondents also recommended an increase of literature in professional or layperson health and wellness journals. Respondents stated that this might be another good opportunity to increase people's exposure to the practice and debunk general population misconceptions. Locally, within the professional organizations of hypnosis one respondent also stated that there did not appear to be any specific organization around informing and educating social workers about the applications of hypnosis. This respondent identified that consultation or study group could be easily organized, but thus far have not.

Discussion

A review of the literature on hypnosis in clinical practice found multiple beneficial applications, such as the treatment of anxiety (Gravitz, 1994; Nugent, 1993), experience of pain (Askay et al., 2007; Lioffi et al., 2006; Smith et al., 1996; Snow & Warbet, 2010), and trauma-related symptoms (Bryant et al., 2005; Lesmana, Suryani, Tiliopoulos, & Jensen, 2010; Malon & Berardi, 1987). However, within the social work profession its beneficial uses appeared to be under-recognized. Complimentary and Alternative Medicines (CAM) overall were discussed in the literature review as a growing area in the field of mental health (National Center for Complementary and Alternative Medicine [NCCAM], 2008), yet, are still very much overlooked and under-researched in the field. The social work profession and its related perspectives, such as the Bio-Psycho-Social Spiritual framework are integrative and holistic by nature (Grant et al., 2009). For that reason, it would appear that the profession would also include more CAM practices, such as hypnosis. Within this literature review, a number of articles were cited in some relation to hypnosis, but only a handful of the studies were published

in social work journals. Therefore, this study asked the question: What factors surround the under-utilization of hypnosis as a therapeutic tool in clinical social work practice?

Seven themes emerged from the data analysis of the seven LICSW respondent transcripts. Again, as discussed in the findings section, these themes included: clinical social work practice with clients, respondent training and knowledge of clinical hypnosis, the healing and empowering benefits of hypnosis, the misconceptions of hypnosis and the related impact in social work, contributing factors to the under-utilization of hypnosis in social work practice, the alignment of hypnosis with the social work profession and code of ethics, and recommendations for hypnosis education. Many of the areas within the literature review addressed the supporting aspects of the themes, and overlapped in some facets. However, given the exploratory nature of this qualitative study there were also several nuances within the data analysis that were not specifically discussed in any of the reviewed articles for this research. Some interesting aspects found from this study included the perspective and ownership of power within the use of hypnosis, the impact of the rather ingrained cultural images of hypnosis, and varying ways in which providers manage these misconceptions. Overall, an ethical clinical practice was cited as the most important aspect in its use. Therefore, the following discussion will incorporate and provide support for the information found in the literature, and furthermore, will speak to some of the additional contributing factors to the under-utilization of hypnosis in the social work profession.

The Implications of Power and Empowerment in Clinical Hypnosis

Client empowerment. The greatest contrast interpreted from the data analysis appeared to be the perspective and ownership of power within the application of

hypnosis. The respondents who provided hypnosis in their clinical practice described numerous presenting concerns in which hypnosis may be utilized as a useful therapy tool. Some of these concerns included pain and anxiety management for children in a hospital setting, somatic complaints (including stomach aches, headaches, pain, and migraine headaches), anxiety (including social and separation anxiety), sleep, and ego strengthening. Again, the use of hypnosis to address some of these concerns including anxiety (Gravitz, 1994; Nugent, 1993), experience of pain (Askay et al., 2007; Lioffi et al., 2006; Smith et al., 1996; Snow & Warbet, 2010), and trauma-related symptoms (Bryant et al., 2005; Lesmana, Suryani, Tiliopoulos, & Jensen, 2010; Malon & Berardi, 1987) were also empirically supported by the literature.

Respondents who use hypnosis in their practice also spoke to the influential power of integrating the conscious and unconscious mind with the body, such as in hypnosis, to facilitate change within the self. Inferences to the role of the therapist in promoting client empowerment were inherent in all of the interviews from hypnosis providers. Respondents described that the use of clinical hypnosis provides clients with a sense of control (*"I don't have to sit in that place of discomfort. I do have options,"*) a means of discovering and uncovering a personal power (*"internal resources..."*), and a way to be "in charge" of their own healing process. Respondents described themselves as being in a facilitator role in the use of hypnosis, and emphasized that the process allows the client's internal and innate abilities to be the catalyst for change. Clients learn how to *"self-calm and self-regulate,"* and in turn are empowered by their own abilities and capacity to take control over their emotional and physiological experiences. While this aspect of hypnosis was not discussed in-depth in the reviewed literature, Mendenhall

(2003) discussed that a framework of empowerment in the social work practice is aligned with the values of respect and integrity of the person. This perspective encourages social workers to see clients' inherent strengths versus a sole focus on their deficits.

Additionally, the empowerment perspective calls social workers to expand their views and practices based on the holistic needs of their clients (Mendenhall, 2003).

Misconceptions of hypnosis – Loss of power. In stark contrast to the responses from hypnosis providers on the empowering aspects of hypnosis were the numerous references to the misconceptions of hypnosis. Respondents referenced the fears from the general population perspective, including that the therapist may possess power or mind control over the hypnosis recipient. References to the images and related experiences of the entertainment world through stage hypnosis were repeatedly named as some of the “*perpetrators*” of hypnosis misconceptions. Images of the pocket watch, suggestions to bark like a dog, sharing personal information unwillingly, and being coerced into other unethical behaviors were cited as general public associations with hypnosis. These images were also noted within the general media, including the “*whirly eyes*” in cartoon portrayals. Respondents also discussed the perception that hypnosis takes the responsibility for change, such as in the case of weight loss or smoking cessation, out of the hands of the hypnosis recipient, and may be viewed as “*magic*.” Again, this association references a general population belief that hypnosis is linked to a loss of self-control or power.

The mystery and power related to hypnosis has been exploited again and again in our culture at the hands of those in the entertainment world. As discussed in the literature review, Lynn et al. (2000) explores the exploitation and lack of ethical practices used in

stage hypnosis. In general, stage hypnotists take advantage of the general population misconceptions to increase the entertainment value of their performances (Lynn et al., 2000). Yet, as seen in this study, the images associated with such acts can be damaging to the therapeutic applications of the hypnosis. Therefore, the weight and strength of these misconceptions increases the importance of maintaining a sound and ethical clinical practice in order to provide a new image of the hypnosis to the general population.

Images exploited in the general media were also discussed in the reviewed literature. Barrett (2006) categorizes a list of 230 films in which hypnosis is utilized in some fashion. In general, the featured storyline in all the films include a protagonist who uses hypnosis to possess control over another person. Barrett (2006) notes that the films during the first half of the 20th century portrayed hypnosis in a very negative and frightening light. In addition, multiple films created within the 1930s to 1960s portrayed a man hypnotizing a woman into desiring him in some way. Authoritarian methods of hypnosis including commands while using a pendulum and concentrated or glowing eyes were often portrayed (Barrett, 2006). A few novels and films of the late 1950s and early 1960s that included hypnosis also exploited the fears of “brainwashing” during the peak of the cold war (Upshaw, 2006). The associations of hypnosis as portrayed by the entertainment industry appear to have abused the general population fear of being controlled, and as a result, have imprinted a negative and sometimes dangerous image of hypnosis into the collective unconscious of society. Researchers have even speculated whether hypnosis should perhaps change its name to something that is more generally accepted due to the long history of negative associations with the word, *hypnosis* (Upshaw, 2006; Wagstaff, 2008).

Within this study, the ingrained cultural images of hypnosis were also shown to create a major impact on its utilization in social work. Clients were identified as being fearful of the practice, because of its misconceptions as “*mind control*” and associated images with stage hypnosis. These misconceptions appeared to be somewhat challenging to work through in some cases, and hypnosis providers described different practices of either teaching clients about hypnosis or avoiding the use of its words and phrases.

Provider perceptions of hypnosis. Respondent perspectives on mental health and medical provider opinions of hypnosis ranged from negative and dismissing to open and interested. Provider knowledge regarding the therapeutic applications of hypnosis as well as the general orientation of the provider to new concepts and interventions were cited as the determining factors in the acceptance or renouncement of clinical hypnosis. Given the current limited use of CAM interventions (NCCAM, 2008) it seems that perhaps providers may be apprehensive about exploring new treatment modalities that are outside of their scope of comfort and base of knowledge. In addition, a limited amount of publication and research on the efficacy of CAM practices, such as hypnosis, may also serve as a contributing factor to its reticence.

Respondent knowledge and concern associated with hypnosis. Overall, respondents who did not use hypnosis in their practice identified that they did not have a good understanding of hypnosis or its related training in therapeutic practice. Responses regarding training in hypnosis only included the fact that extensive training is needed. Images and experiences of stage hypnosis surfaced in association with its applications. Some respondents who did not use hypnosis in their practice also appeared to carry fear surrounding losing control, (“*fear of not wanting to overstep my boundary or be*

unethical”), taking power away from the client, or unintentionally causing them harm. As identified in the literature review, Reamer (2006) warns of the potential harm to clients or malpractice suits that could befall social workers if they were to use an intervention outside of their competency. Again, while this recommendation of social worker competency is essential for sound clinical practice it may also inadvertently deter social workers from expanding their breadth of expertise based on apprehensions related to unknowingly intervening against the client’s best interest.

False memories. Respondents who did not use hypnosis in their clinical practice also identified the concern of false memories emerging during therapeutic practice. These concerns of false memories appeared to specifically surround the uncovering of repressed sexual abuse memories, which may have been publicized in the media several years ago. Interestingly, none of the providers of hypnosis addressed this concern during the interviews. This divergence may have been due to the differences in knowledge related to hypnosis, but nonetheless highlight further social worker concerns and apprehensions in the use of clinical hypnosis.

Gravitz (1994) cautions that providers who use hypnosis to explore memories from the past must be aware of the concerns related to memory distortion that are present even with non-hypnotic memory recall practices. As discussed in the literature review, concerns of inaccurate or false memories began emerging in the 1970s and 1980s during the use of hypnosis to refresh eyewitness accounts during police investigations (Upshaw, 2006). The American Medical Association then concluded in the mid-1980s that memory recall through the use of hypnosis may produce unreliable or inaccurate accounts (Upshaw, 2006). While the effects of false memories does not necessarily occur in the

majority of cases during memory exploration under hypnosis (Upshaw, 2006) it appears to still have further tainted the image and association with negative or unethical practices.

Fear of self-empowerment. Within a few of the transcripts, respondents noted that clients have previously described an association between hypnosis and “Satan” or “devil worship.” In general, it is quite possible that these connections may in part be related to the inaccurate images from the public media and entertainment world. However, given the strong sense of empowerment surrounding the practice as described by the hypnosis providers it is perhaps also possible that things that empower us as individuals can also be seen as overwhelming, unnatural, or even evil. As one respondent stated, *“I think that a lot of people refrain from things that actually empower themselves. Because we’re used to a pill, going to the doctor, not taking responsibility for our health care.”* In our culture, health care and healing are generally associated with external forces, such as medication and paternalistic and specialized medical services that are outside of our selves. Therefore, the possibility that healing can come from within may seem quite foreign or unrealistic. If hypnosis is viewed from either the perspective as a power outside of our control or as a great and unnatural internal power it may then become associated with negative influences or evil.

Implications of Social Work Training and Perspectives on Research and Practice

Respondents identified several factors related to social work graduate training and perspectives that may impact the use and research of hypnosis in the profession. The following will discuss the impact of these dynamics.

Graduate training. Several respondents spoke to concerns that their graduate training was overly *“theoretical”* and *“philosophical,”* and did not offer an in-depth

understanding of the theories and applications of clinical social work practice.

Respondents recalled receiving encouragement to continue with ongoing self-motivated education, and endorsed an experience of strengthening their understanding of theory within their field and employment placements. One respondent even remarked that in his or her opinion social workers were not trained well to do therapy. These general views from respondents about their graduate training were a new finding for this study. As identified in the findings section, several respondents described their theoretical approach as “*eclectic*”, which may be aligned with the social work perspective of beginning the work where the client would like to begin (Miley et al., 2007). However, this description may also be impacted by the respondents’ reflections that their graduate training was not as solidly grounded in theory and application.

In regards to hypnosis, the majority of respondents noted that hypnosis, nor its applications, were a part of the curriculum taught during their graduate training. Respondents who use hypnosis in their practice identified learning about the intervention from someone they knew or through a training experience. Respondents who do not use hypnosis identified that since hypnosis was not discussed in-length during graduate school as some applications, such as Cognitive-Behavioral Therapy, there is now not the same level of understanding about the intervention. These findings are in agreement with the reviewed article by Grant et al. (2009) who states that integrative health care approaches tend not to be included in the curriculum of social work education. Yet, including integrative health care practices, such as hypnosis, in social work training may serve as another means by which social workers tend to the holistic needs of their clients (Grant et al., 2009).

Curriculum for graduate social work programs are formulated around well-established, evidenced-based theories and approaches for practice. Since CAM-related approaches may not have the same research-base, and may appear more novel or nascent, graduate programs may be more skeptical about incorporating such practices. The cyclical effects of limited research, knowledge, and applications seem to impede upon the advancement of integrative therapies that could be quite beneficial for the holistic needs of clients. Incorporating more articles and discussions on alternative therapeutic practices at the graduate level may serve as a starting point to expanding the views of the social work profession.

The impact on research and publication. Several respondents discussed their perspectives regarding the lack of research in the social work profession. Respondents identified factors including a stronger interest in practice over research, and the amount of work and lack of reimbursement related to research. Additionally, a few respondents commented on the perspective that psychologists tend to have a more solidified theoretical framework for practice and therefore, may be more likely to engage in research in order to empirically support their theoretical perspectives and approaches. Another respondent also identified the opinion that psychologists and those in the medical profession tend to be seen as more credible than social workers, because they actively engage in clinical research. These statements speak to the findings connection between a strong theoretical foundation, research, and professional credibility.

The vast majority of respondents identified Cognitive-Behavioral Therapy and its related approaches as strongly supported by evidenced-based practices. Additionally, one respondent recalled learning the steps and approaches of CBT during graduate training.

However, only one respondent identified hypnosis as an evidenced-based approach. As seen in the literature review, multiple studies have been completed and published on the evidenced-based practices of clinical hypnosis (Askay et al., 2007; Bryant et al., 2005; Gravitz, 1994; Lesmana et al., 2010; Lioffi et al., 2006; Malon & Berardi, 1987; Nugent, 1993; Smith et al., 1996; Snow & Warbet, 2010). Yet, hypnosis was under-identified as an evidenced-based intervention. More visible articles and research appears to be needed, particularly in the social work profession, to support the credibility of hypnosis in the mental health field. Thyer (2007) concurs with the need for further evidenced-based research within the social work field, and describes this as a “sin of omission” (p. 28) in the profession.

Grant et al. (2009) speculates that the lack of integrative health care curriculum in graduate social work training is related to the lack of empirically supported research in the field. This concern would then also impact the role of publication, and consequently, lack of knowledge regarding the evidenced-based practices. As earlier noted, this vicious cycle of limited research impacting the knowledge, practice, and training seems to be greatly influencing the use of hypnosis in the social work profession. Kirsch et al. (1993) notes that the fruitfulness of hypnosis in the mental health field will stand or fall on the basis of validated, evidenced-based research on the efficacy of hypnosis in clinical practice.

Social work perspectives. Several respondents spoke to the factor of social work perspectives on the impact of hypnosis use in the profession. Respondents identified that social work theories and perspectives, such as Bio-Psycho-Social-Spiritual and Person-In-Environment are holistic in nature, and view the individual in relation to the world

around them. These perspectives were identified in the conceptual framework of this paper as the building blocks of social work practice, that are integrative and encompassing of the human experience (Grant et al., 2009; Miley et al., 2007). Yet, as one respondent suggested, the specialty training and use of hypnosis may not fit with the broad social work perspective. However, as Grant et al. (2009) indicates, knowledge about the spectrum of uses and unique view of integrative health care may help individuals to see how interventions, such as hypnosis, can fit with the social work approach. Additionally, integrative approaches may also promote further attention and inclusion of the holistic needs of clients (Grant et al., 2009). In summary, knowledge and education about the function and applications of hypnosis may provide a different perspective of the intervention that is more aligned with the holistic view of the Bio-Psycho-Social-Spiritual Perspective than previously believed.

Another factor addressed by respondents was the various systematic lenses, including micro and macro that may perhaps create divergence within the profession in regards to continued training and research. Miley et al. (2007) describes that the environmental subsystems of micro, mezzo, and macro form together to create a perspective of how the world is impacting clients on various levels. Yet, within the profession, some social workers may settle into their practice at the macro level and some at the micro level. Respondents speculated if this “split” in the profession could also impact the under-utilization of hypnosis in the profession as well as the identified lack of research overall.

The Role of Ethics within Clinical Hypnosis in the Social Work Profession

Whether experienced from the perspective of strength or deficit it is clear that the

view of hypnosis is one associated with great power. However, with this power also comes the responsibility to use hypnosis 100% ethically in application and practice. In an example of a potential professional abuse of power, a respondent recalled the concerning and unethical interaction experienced as an adolescent in which inappropriate touch was used under the guise of hypnosis. Unfortunate stories such as this further add to the negative associations with hypnosis due to the unethical practice behaviors of clinicians. Given the challenging history of hypnosis in the face of stage entertainment (Grindstaff & Fisher, 2006; Lynn et al., 2000; Wagstaff, 2008) exploited media images (Barrett, 2006; Uphsaw, 2006), risk of pseudo-memories (Kirsch et al., 1993; Voit & DeLaney, 2004; Upshaw, 2006), and clinical misuses (Flatow & Nathan, 2011; Strickler, 2011) the work towards promoting the healing and empowering aspects of hypnosis seems to be an uphill battle. Within social work, adherence to the code of ethics appears to be the key to an upstanding practice.

An empowering and ethically sound practice. Respondents were somewhat diverged in their opinions of the alignment of hypnosis with social work practice and code of ethics. Respondents who use hypnosis in practice endorsed beliefs that hypnosis is perfectly aligned with the social work profession, because of the inherent and central aspect of empowerment and connecting to the self. As Knight (1991) describes, hypnosis helps clients to facilitate an awareness and access to the resources within themselves. Yet, respondents who did not use hypnosis in clinical practice were more cautious in their endorsement of hypnosis being aligned with the social work profession. Non-hypnosis providers stressed the importance of using informed consent and professional judgment to avoid unintentional harm of clients. In addition, non-hypnosis providers emphasized

the responsibility of clinicians to be competently trained in its use, and to practice in a healthy and positive manner. While these recommendations are absolutely valid and essential, some appeared to stem from preconceived beliefs about hypnosis, including the misconception that recipients are not conscious during the process.

Voit and DeLaney (2004) point out that the use of hypnosis begins with a solid clinical practice; providers should only use hypnosis with the client concerns that they are competent in treating outside of the intervention. In addition, professional expertise, continuing education, healthy boundaries, informed consent, supervision, and agreed upon expectations between the client and the therapist also provide a healthy practice framework (Snow & Warbet, 2010; Voit & DeLaney, 2004). Adherence to the code of ethics can help to decrease provider apprehensions and encourage training and integration of hypnosis in practice (Voit & DeLaney, 2004). Overall, integrating the perspective of the client empowering nature of hypnosis along with the recommendations to maintain an ethical practice will further strengthen the use of hypnosis in the profession.

Managing the misconceptions of hypnosis. The respondents who use hypnosis in their practice appeared to address client misconceptions and fears about hypnosis by either providing or avoiding education about its practice, use, history, and myths. Some hypnosis providers responded to their clients' misconceptions by inquiring and clarifying previous beliefs, and offering as much education on the practice as the clients requested. Some of these clarifications included the fact that hypnosis recipients are always in control and conscious during the process. These respondents tended to identify that the process of providing education helped to decrease the negative associations and increase client's interest in the intervention.

In contrast, some respondents described a practice of avoiding the word hypnosis and its related terminology, because the misconceptions appeared to be too overpowering and time-consuming to work through. Instead, some respondents identified using hypnosis, but described the intervention to clients as relaxation and mindfulness. Grindstaff and Fisher (2006) found similar results in their qualitative study with sports psychology consultants and athletes. They found that some consultants tended to avoid the use of the word hypnosis, because of the amount of time needed to dispel the misconceptions. Grindstaff and Fisher (2006) cited concerns related to the potentially unethical practices that can occur when informed consent is not utilized. As earlier discussed, adherence to the code of ethics, particularly the use of informed consent and client right to self-determination, are essential for quality client care, and to improving the tainted image of what is truly a healing and empowering intervention.

Respondents who described avoiding the use of the word hypnosis also cited the similarities between hypnosis and other relaxation techniques (including use of the breath and body) as justifications. Factors such as the negative history and connotations of hypnosis, as well as the recent social trend of “being mindful” were explained. Yet, although hypnosis shares many of its elements with practices of relaxation and mindfulness a notable difference includes the role of suggestion within the trance induction (Lankton, 2001; Winsor, 1993). In addition, the theories related to hypnotic trance (disassociating the conscious mind from the unconscious mind) are different than that of relaxation (Kirsch et al., 1993). Furthermore, based on the findings, hypnosis appears to engage clients in a deeper relaxed state in which specific techniques, such as age regression (Gravitz, 1994), can be utilized. Finally, the clinical practice of hypnosis

also requires additional trainings, practice, and consultation in order to ethically engage clients in its use.

Overall, an adherence to the Social Work Code of Ethics (2008) appears to be the best guide for clinical practice with hypnosis. Informed consent and clients' right to self-determination appear to be at the forefront. Informed consent is essential for a sound and ethical therapeutic practice regardless of the intervention used. Therefore, clients have a right to know what intervention the social worker is using so that they can make a choice as to whether or not they agree to treatment. Along those same lines, clients' right to self-determination gives the decision-making power to the client who can then determine what interventions they are comfortable with in the therapeutic relationship. Providing education and clarity on the practice, functions, uses, and myths of hypnosis allows the client to make a conscious decision, including the use of hypnosis in therapy.

Nonetheless, regardless of the amount of education a clinician provides, the client still has the ultimate choice to accept or decline. As Voit and DeLaney (2004) describe, the fundamental integrity of hypnosis is rooted in the professional and ethical practices of the therapeutic community of practitioners.

Implications

Hypnosis Education and Training

Several implications for the practice of clinical hypnosis and social work emerged based on this qualitative research study. A number of respondents who use hypnosis in their practice identified the commitment to ongoing training, consultation, and practice needed to become competent in its use. As identified in the findings section, one

respondent who has been practicing hypnosis for five years self-described as “*middle of the road.*” This information highlights the importance of continuing education.

However, several professional organizations hold varying requirements for certification and competency. For example, the number of peer-reviewed training and consultation hours may differ based on the professional organization. Therefore, one suggestion may include exploring some level of unity within professional certification. A unified training process or professional certification within the clinical application may help to distinguish the clinical practice from the entertainment industry.

Advertisement and visibility about the clinical uses of hypnosis as well as local training opportunities also appear to need increased attention. A few respondents who do not use hypnosis in practice stated that they would be interested in attending general forums or meetings just to learn more the intervention and its applications. In addition, publications in professional journals, lay-person wellness newsletters or magazines may offer increased exposure to the clinical practice while also clarifying and educating the public about its therapeutic uses. A few respondents identified that masters-level clinicians don't seem to know about the training opportunities available locally through the Minnesota Society of Clinical Hypnosis or even know that they are qualified to undergo the trainings. Increased discussions and publicity through graduate school announcements, mailings, emails, and updated website information would help to reach eligible professionals.

In addition, professional organizations that train providers in the use of hypnosis may benefit from more specifically emphasizing its ethical implications, including the importance of adhering to one's professional code of ethics. Tangible and clear language

regarding how to manage the misconceptions of hypnosis may help clinicians to more easily discuss its use in therapeutic practice. A clear stance regarding informed consent and client right to self-determination seems imperative. Additionally, public advertisement of the hypnosis code of ethics, such as on publically accessible website, may also help to alleviate provider and client anxieties regarding its clinical use.

Social Work Education

Several respondents commented on their opinion that graduate social work training does not offer an in-depth learning experience for future clinical social workers in therapy. From the findings, it also appears that this concern may be a contributing factor in the decreased professional research and publication within the profession. Given this finding, examining the clinical social work application involved in graduate level training may be needed. It is clear, however, through respondents' endorsements regarding the importance of "use of self" that the graduate training experience does provide learning around the authenticity needed in therapeutic work. As one respondent shared, "*Social work prepared me more for the human part about being a therapist.*"

Integrative psychotherapy education. If social workers are to maintain their commitment to the values of the profession they must advocate for the holistic needs of their clients and engage in ongoing education to strengthen their professional competencies (Grant et al., 2009; Mendenhall, 2003). One way that this could occur in graduate education is through the learning experiences of integrative health care and psychotherapy. One respondent commented on the need to integrate clinical practices that address and stimulate both left and right brain activity. The opportunity to learn integrative interventions, such as hypnosis, would offer graduate social work students a

new perspective on holistic client care. As one respondent stated, *“It’s going to take another 18 ½ years before hypnosis, EMDR, and energy psychology finds it’s way into these schools and parlance for really effective clinical application. And if it never does? What a great loss.”* The empowering and transformational aspects of clinical hypnosis as found in this study highlights the great loss that the profession would experience if this tool never became apart of the evidence-based practices of the social work profession.

Research Strengths and Limitations

This research study had several strengths as well as limitations. The qualitative nature of the study allowed for the collection of subjective beliefs and perspectives of social worker, and offered a deeper understanding of the obstacles surrounding the use of hypnosis in the social work profession (Monette et al., 2008). Qualitative research emphasizes the importance of letting the theories emerge from the data instead of using data to support existing theories (Monette et al., 2008). To this researcher’s knowledge, no other qualitative study has been conducted on the investigation into the under-utilization of hypnosis in clinical social work practice. Therefore, the nature of this study was exploratory, and the findings will add to the body of research on the topic while also helping to dispel misconceptions.

Several limitations also exist within this study. The qualitative research of the study, and limited number of respondents threatened the study’s internal validity. By it’s nature, qualitative research is subjective, and the data cannot be measured through objective analysis. In addition, some limitations to the snowball sampling method of the research include the possibility of missing potential respondents who are not involved in strong social networks (Monette et al., 2008). As a consequence, the results cannot be

generalized to the total population of social workers. In spite of this, the qualitative data will still begin to add a “voice” to the limited available research on the study of the under-utilization of hypnosis in clinical social work practice.

Conclusion

In conclusion, the evolution in understanding hypnosis practices and its related uses has undergone tumultuous changes in the last 300 years, and has been met with enthusiasts and skeptics throughout. Its mystery and powerful applications have also led to its exploitation in the media and entertainment industry. The acceptance of hypnosis as a clinical tool for social work practice was found through this study to face many obstacles including: misconceptions and lack of knowledge, limited publicized research and layperson writings, and limited integration in graduate training. Variances in the macro and micro lenses of social work perspectives were also cited as possible factors in its under-utilization. However, as this study has shown, hypnosis is aligned with the social work emphasis on client empowerment, and helps providers attend to the holistic needs of clients. A firm observance to the social work code of ethics was concluded as being essential to a sound, clinical practice. The incorporation of discussions, readings, and classes at the graduate level surrounding integrative therapies, such as hypnosis, is recommended. This inclusion will help to expand the competencies of emerging social workers, and as a result, can assist in addressing the multi-faceted needs of the clients served in the profession.

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Appendix A Recruitment Letter

Greetings,

My name is Amanda Olson, and I am a graduate social work student at St. Catherine University/University of St. Thomas School of Social Work. I am conducting a qualitative research study on the under-utilization of hypnosis in clinical social work practice. The purpose of this study is to explore potential factors surrounding the obstacles and advances in the perspective and use of hypnosis as a therapeutic tool in the mental health field.

The study is recruiting potential respondents who may be willing to be interviewed one-on-one regarding this topic. The study is seeking eight respondents who are clinically licensed mental health clinicians in the field of social work, psychology, marriage and family therapy, or professional counseling (i.e. LICSW, LP, LMFT, or LPC), are in good standing with their respective board, and practice clinical work in an outpatient clinic, private practice, or hospital setting. Respondents may or may not have knowledge about the use of hypnosis in clinical practice, however, in either case their perspective will be valuable to this study.

In addition to the above criteria, the study is also seeking respondents who have experience using hypnosis in clinical practice, and have completed at least 20 hours of training on hypnosis through a professional organization.

For the purposes of data collection, the interview will be audio recorded and transcribed. Any identifying or identifiable information about the respondent will be removed during transcription to protect confidentiality. This study has no risk or direct benefits, and has been approved by the Institutional Review Board of St. Catherine University.

If you are interested in participating in a 45-60 minute interview for this study, or have additional questions please contact me, Amanda Olson.

Thank you,

Amanda Olson

Appendix B
RESEARCH INFORMATION AND CONSENT FORM
SAINT CATHERINE UNIVERSITY

**FACTORS THAT INFLUENCE THE UNDER-UTILIZATION OF
HYPNOSIS IN CLINICAL SOCIAL WORK PRACTICE**

Introduction:

You are invited to participate in a research study investigating the under-utilization of hypnosis in clinical social work practice. Amanda Olson, social work student in the Graduate Social Work Program at St. Catherine University, is conducting this study. You were selected as a possible participant in this research, because you are a clinically licensed mental health clinician in the field of social work, psychology, marriage and family therapy, or professional counseling (i.e. LICSW, LP, LMFT, or LPC), are in good standing with your respective board, and practice within an outpatient, private practice, or hospital setting. You may or may not have knowledge about the use of hypnosis in clinical practice, however, in either case your perspective will be valuable to this study.

If you have experience using hypnosis in clinical practice you were selected, because you have completed at least 20 hours of training through a professional organization such as, The Society for Clinical and Experimental Hypnosis, The American Society of Clinical Hypnosis, The International Society of Hypnosis, Minnesota Society of Clinical Hypnosis, or a similar organization. Furthermore, you also may have established competency in clinical hypnosis through workshops, professional readings or self-study, clinical consultation, and the use of hypnosis in your clinical practice. Please read this form and ask questions before you decide whether to participate in the study.

Background Information:

The purpose of this study is to investigate respondents' graduate training, theoretical framework, clinical practices, and opinion regarding the use of hypnosis as an alternative mental health intervention. In addition, the respondent's use of hypnosis in clinical practice, if any, will be explored. Professional and general population beliefs regarding hypnosis, and its alignment with the social work profession will also be addressed. Approximately four clinicians who practice clinical hypnosis and four who do not are expected to participate in this research for a total of eight people.

Procedures:

If you decide to participate, you will be asked to take part in a face-to-face interview in a private, agreed upon location. The consent form will be reviewed together prior to the interview, and you will be given an opportunity to ask questions. The interview will consist of approximately 12-17 questions pertaining to the topic of clinical hypnosis for the purpose of collecting information on your practice and perspective. You will not be asked to provide any information regarding your practice that would violate the confidentiality of the clients you serve. In addition, the interview will be audio recorded.

The estimated length of time of the interview is 45 to 60 minutes. Upon completion of the audio-recorded interview, the recording will be transcribed, and will omit any information that may identify your personal information. Following transcription, the data will be analyzed, and written within the “Results” and “Discussion” portion of the research paper. The faculty advisor and research chair, Dr. Sarah Ferguson PhD, may review the transcripts and data analysis for reliability purposes.

Risks and Benefits:

This study has no risks.

This study has no direct benefits.

Confidentiality:

Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. Research records will be kept in a locked file at my home in a desk drawer. I will also keep the electronic copy of the transcript in a password-protected file on my computer. I will be the only person who will have access to the locked drawer and password-protected file. The faculty advisor and research chair, Dr. Sarah Ferguson PhD, may review the transcripts and research paper, but will not know who you are. For educational purposes, the research data will be presented during a clinical research presentation in May 2012, and a copy of the completed research project will be provided to the St. Catherine University/University of St. Thomas Graduate Social Work Program. The audio recording and transcript will be destroyed by June 1, 2012.

Voluntary nature of the study:

Participation in this research study is entirely voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work in any way. If you decide to participate, you are free to skip any questions you do not wish to answer, and may stop the interview or withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be used.

Contacts and questions:

If you have any questions, please feel free to contact me, Amanda Olson. You may ask questions now, or if you have any additional questions later, the faculty advisor and research chair, Dr. Sarah Ferguson PhD, will be happy to answer them. If you have other questions or concerns regarding the study, and would like to talk to someone other than the researcher you may also contact Lynne Linder, IRB Assistant of the St. Catherine University Institutional Review Board.

You will be given a copy of this form to keep for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audio recorded.

Signature of Participant

Date

Signature of Parent, Legal Guardian, or Witness
(if applicable, otherwise delete this line)

Date

Signature of Researcher

Date

Appendix C Interview Questions

1. Can you tell me a little background information on your education and professional discipline, number of years in practice following licensure, main client population, and the setting you work in?
2. Can you provide a summary regarding your theoretical framework for clinical practice including some of the clinical approaches you use with clients?
3. How does your own personal theoretical framework correspond to the theories and approaches of your discipline? Follow up: and the graduate level training you received?
4. Can you explain what the term “evidenced-based” means to you? Follow up: What mental health interventions come to mind surrounding this phrase?
5. Now we are going to transition to questions regarding hypnosis. Do you use hypnosis in your clinical practice with clients? If so, please describe the setting, client population, presenting client concerns, and length of time you have been using hypnosis?

(Skip to question #8 if the respondent reports that he or she does not use hypnosis in clinical practice.)

6. How do you believe hypnosis benefits your clients, and the therapeutic work you are doing together?
7. Can you share some of the feedback, positive or negative, you have received from clients regarding the intervention of hypnosis?

(Skip question #8 if the respondent uses hypnosis in practice)

8. Can you speak to your general knowledge about hypnosis, and any of its related history or research in the mental health field that you can recall?
9. In your opinion, what are some preconceived beliefs, influences, and images that the general population associates with the use of hypnosis?
10. How do you believe the preconceived beliefs of the general population affect the use of hypnosis in the mental health field?
11. What are some differences, if any, between the knowledge or preconceived beliefs within the general population and the knowledge or beliefs of those in the mental health field regarding hypnosis?

12. A limited amount of the research I reviewed for this study was written by clinical social workers. The vast majority was instead published in either medical or psychological journals.

What factors do you see surrounding the lack of utilization, research, and publication regarding hypnosis in the social work field?

13. Do you believe that the use of hypnosis is aligned with the social work profession and the social work code of ethics? Why or why not?
14. What strategies would you suggest surrounding public and provider education regarding clinical hypnosis?

(Extra questions if time permits.)

15. Can you speak to your knowledge about training and ethical standards in the use of hypnosis?
16. The term *CAM* or *Complementary and Alternative Medicine* has been described as a broad and diverse group of health care practices, and their accompanying theories and beliefs, which typically fall outside of the present category of conventional medicine within Western culture. *Complementary medicine* is used in conjunction with conventional medicine, and *alternative medicine* is used in place of conventional medicine.

Can you speak to your opinion on whether CAM practices should or should not be more widely included in social work education curriculum?

17. Can you speak to the obstacles, if any, you perceive in recommending, accessing, or using CAM practices?