

## Article 47

### **Hypnosis and the Counseling Profession**

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#### **Abstract**

Almost 50 years ago, scientist and clinical psychologist Alfred Barrios inquired as to why hypnosis was not widely used as a clinical intervention. Today, this question continues to be pertinent. This article explores this question in more depth and provides a contextual overview of the evolution of hypnosis. A rationale is provided to support the use of clinical hypnosis as an effective intervention. Additionally, the integration of clinical hypnosis with cognitive behavioral therapy for the treatment of physical and mental health conditions, such as depression, anxiety, and irritable bowel syndrome is presented. Implications and recommendations for counselors and counselor education programs are discussed.

*Keywords:* clinical hypnosis, cognitive behavioral therapy, counseling, anxiety, depression, irritable bowel syndrome

As a new counseling professional, a powerful influence in my quest to learn more about hypnosis as a clinical tool was experiencing firsthand the daily battle of people who are trying to control addiction. Over the past 10 years, the study, practice, and training in clinical hypnosis (CH) has enriched my life both personally and professionally. Personally, I used self-hypnosis to undergo a small surgical procedure without general anesthesia. Professionally, the addition of CH to my counselor's toolkit has been invaluable in assisting clients with smoking and tobacco cessation, chronic nail biting, anxiety, grief and loss, ego strengthening, and general wellness.

Exposure to CH is generally not standard fare in counselor education programs. Similar to areas of expertise such as Eye Movement Desensitization and Reprocessing (EMDR) or Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), competency in

CH requires specialty training. In my current role as a professional clinical counselor supervisor (PCC-S) practicing in an integrated health care environment, and as a doctoral student with an inquiring mind, a deeper exploration into the possibilities of CH as an effective clinical tool is warranted.

The purpose of this paper is four-fold. The first aim is to provide context with a brief overview of hypnosis, including definition, history, criticisms, and concerns. The second aim is to review the research exploring the efficacy of the application of CH in the treatment of mental and physical health conditions. Third, a rationale is offered to support the application of hypnosis as an effective intervention for professional counselors. Fourth, implications and recommendations for the counseling profession are discussed.

### **Hypnosis: Definition and History**

Much debate has ensued over the years about the definition of hypnosis. In fact, one of the challenges in the study of hypnosis has been the lack of a consistent definition (Patterson, 2010). Today, the leading authorities in the study and practice of hypnosis concur that hypnosis is a natural state of highly focused concentration and attention during which the capacity to receive suggestion is enhanced (American Psychological Association, 2016; American Society of Clinical Hypnosis [ASCH], 2015a; Society of Clinical and Experimental Hypnosis, 2016).

For human beings, altered states of consciousness are a natural part of everyday life. Consider the transition from sleep to awake, daydreaming, or that sense of losing time after being completely engrossed in a favorite pastime or activity. These are all modern-day examples of altered states of consciousness (ASCH, 2013).

#### **Hypnosis' History**

The roots of hypnosis are extensive, reaching back to ancient Hinduism, the Egyptians, and the early Greeks. History is littered with examples where words, suggestion, and the imagination have been attributed to the healing process. Homer, the Greek poet, described the power of words in his poem *The Odyssey*. After being impaled by a boar on a hunting trip, Odysseus' wounds were bound and his "black blood" was "stayed with a song of healing" (Ludwig, 1964, p. 209). Evidence for the use of imagination and suggestion to treat disease and insomnia can be found in early Egyptian writings. Additionally, the ancient Hindus emphasized imagery and sound in their healing rituals (Ludwig, 1964; Mutter, 2011).

Fast forward to the 16th century and Athanaasius Kircher (1602–1680), a German mathematician and physicist, was advancing a theory about invisible energy created by magnetic particles, which were thought to be found throughout the natural world. Kircher believed that these magnetic particles were instrumental in the process of disease and healing (Ludwig, 1964; Mutter, 2011). Kircher suggested that the invisible fluids found universally in nature could be redirected, or re-balanced, at will with the use of *magnetism*. Once internal harmony was restored, disease would remit and good health would return (Ludwig, 1964).

Physician Franz Mesmer (1734–1815) elaborated on these concepts. Mesmer understood *magnetism* as an invisible energy that flowed between doctor and patient (Mutter, 2011). As Mesmer rose in notoriety, *magnetism* evolved into *mesmerism*.

*Mesmerism* combines the use of touch and suggestion creating a trance or altered state of consciousness. During this period, mesmerism/hypnosis was considered an area of expertise in the medical profession. Today, *mesmerism* is recognized as an early precursor to hypnosis (ASCH, 2013; Ludwig, 1964).

James Esdaile (1808–1859), a British surgeon, studied hypnosis as a replacement for general anesthesia (Ludwig, 1964; Mutter, 2011). Esdaile’s findings suggested that surgery, using a hypnosis-only protocol, was found to decrease mortality rates, increase recovery times, and reduce discomfort in his sample population (Patterson, 2010). Esdaile presented his findings to the Royal Academy of Physicians in London. His research was ridiculed and, consequently, Esdaile and his work were banished from the scientific community.

During the early 19th century, the quest to understand and explore the human unconscious became a new frontier in science. During this period, Sigmund Freud (1856–1939), fascinated by the unconscious mind, studied hysteria and hypnotic suggestion. Freud believed in the existence of a psychological unconscious where thoughts, memories, and perceptions unconsciously lie, influencing our everyday actions and experiences. Freud theorized that hypnosis was the best method to bring unconscious psychological drives into conscious awareness (Kihlstrom & Hoyt, 1990). As a result, Freud developed a deep understanding of hypnosis and became well versed in the dynamics of the hypnotic relationship. Although Freud’s attention shifted from hypnosis to psychoanalysis, the psychodynamic technique of free association and the subsequent interpretation is recognized as an indirect method of suggestion (Kline, 1972). By the late 19th century, Freud’s psychoanalytic theory and techniques evolved, eventually growing in popularity. The underpinnings from psychoanalytic theory can be found in modern psychotherapy and counseling techniques (Frew & Spiegler, 2013). Today, traces of Freud’s roots in hypnosis can be seen in the iconic symbols of the couch and the doctor/patient dynamic.

A history of hypnosis would not be complete without discourse regarding the father of hypnosis, Milton H. Erickson (1901–1980). Erickson, fascinated by the power of language and suggestion, was strongly influenced by his personal struggle with polio as a child and, later, by his work with families (ASCH, 2013). Erickson viewed hypnosis as “essentially, no more than a means of asking your [clients] to pay attention to you so that you can offer them some idea which can initiate them into an activation of their own capacities to behave” (Erickson, 1960/1980, p. 315). Central to Erickson’s practice is language and the art of communication, coupled with counseling principles, such as rapport building, comprehensive assessment, overcoming resistance, and suggestions for positive behavior change (Otani, 1989). In the past 50 years, principles from Ericksonian hypnosis have been applied to the treatment of many mental and physical health complaints in an array of populations and environments, spanning several continents (ASCH, 2013; Gunnison, 1990; Otani 1989; Zahourek, 2002).

Only 47 years ago, an article titled “Hypnotherapy: A Reappraisal” was published in *the Journal of Psychotherapy* (Barrios, 1970). In this article, Barrios questioned the incongruence between the evidence supporting the effectiveness of hypnosis and the dearth of therapists using hypnosis as a clinical intervention. Additionally, Barrios (1970) highlighted the claims about the therapeutic benefits of hypnosis in the treatment of an array of diagnostic disorders, including anxiety, obsessive-compulsive disorder,

alcoholism, and asthma. Barrios also acknowledged that criticisms and concerns surrounding the use of hypnosis were likely barriers for mental health professionals considering the addition of hypnosis to their clinical practice.

Today, clinical hypnosis (CH) is a term used for hypnotherapeutic techniques that include the ethical use and practice of hypnosis by a licensed health or mental health professional in a clinical setting for clinical purposes. The practice of CH is guided by professional organizations such as the American Psychological Association's Division 30: Society of Psychological Hypnosis, the American Society of Clinical Hypnosis (ASCH), and the Society of Clinical and Experimental Hypnosis (SCEH). Each organization offers training and certification programs, ethical codes of practice, and annual scientific conferences. Furthermore, since the mid-1950s, an extensive body of peer-reviewed literature has been published in journals such as the *International Journal of Clinical and Experimental Hypnosis* and the *American Journal of Clinical Hypnosis*. The next section will provide an overview of the common criticisms and concerns about the use of hypnosis.

### **Hypnosis: Criticisms and Concerns**

During the 1970s and 1980s, concerns arose regarding the ethics and safety of the use of hypnosis. Worries about the use of hypnosis for memory retrieval in civil and forensics cases, accounts of guilty defendants being exonerated after false memories were presented as evidence, and stories about distressed patients being under the control of a hypnotist can be seen in the literature (Coons, 1988; Orne, 1979) Wilson, Greene, & Loftus, 1986). These concerns, coupled with limited rigorous empirical evidence to demonstrate efficacy, a dearth of best practice protocols and guidelines, and no universal definition for hypnosis, provide a plausible explanation for the general wariness about the use of hypnosis in the counseling profession. The American Counseling Association's (ACA) *Code of Ethics* (2014) is clear about the importance of client safety and ethical practice. Consequently, if an intervention is perceived as unethical or harmful, then it stands to reason that such practices would be avoided.

Another factor that may limit the consideration of CH as an effective clinical tool is lack of exposure to discourse, literature, and training in programs that educate mental health professionals (Alladin & Alibhai, 2007; American Psychological Association, 2016; ASCH, 2015b; SCEH, 2016). For example, access to scientific journals dedicated to the field of CH, such as the *International Journal of Clinical and Experimental Hypnosis* and *American Journal of Clinical Hypnosis*, is generally unavailable through academia's electronic databases. Furthermore, texts used to teach theories and techniques courses in counselor education programs, such as Frew and Spiegler's (2013) text, *Contemporary Psychotherapies for a Diverse World*, omit any discussion about CH. To illustrate, Frew and Spiegler's text references hypnosis twice in 606 pages; the first mention is a comment regarding Freud's use of hypnosis to treat "hysterical symptoms" (p. 41). The second reference to hypnosis is in context to Freud concluding "that memories of 'seductions' produced by hysterical young women in hypnosis or through free-associations were actually fantasies" (Frew & Spiegler, 2013, p. 46). In comparison, the same text dedicates 45 pages to discussion about Freud and psychoanalytic theory.

In sum, it seems that the combination of concerns around safety and ethics, lack of best practice guidelines, limited empirical research, reduced exposure to discourse, literature, and training may be responsible for the lack of consideration of CH as an effective clinical tool (Alladin & Alibhai, 2007; American Psychological Association, 2016; ASCH, 2015b; Barrios, 1970; SCEH, 2016). The next section provides a review of the current literature exploring the efficacy and utilization of CH as an effective clinical intervention.

### **Clinical Hypnosis: Research and Efficacy**

As mentioned above, researchers and practitioners from the field of hypnosis conjecture that CH fails to be seen as an effective clinical intervention due to the lack of rigorous empirical evidence supporting efficacy (Alladin & Alibhai, 2007; ASCH, 2013; Barrios, 1970; Yapko, 2010). Interestingly, researchers Lynn, Barnes, Deming, and Accardi (2010) countered, arguing that, in fact, over the last 30 years, a large body of research has been published supporting CH as an effective intervention in the treatment of chronic pain, anxiety, obesity, depression, and other disorders (Alladin & Alibhai, 2007; Barrios, 1970; Patterson, 2010; Yapko, 2010).

For over 40 years, psychologist Michael Yapko, for example, has studied, practiced, and written extensively about the use of CH as an effective intervention for the treatment of depression (Yapko, 2006). Yapko highlights two empirical studies supporting the efficacy of CH. The first study, a meta-analysis conducted by Kirsch, Montgomery, and Sapirstein (1995), was designed to explore the use of CH to enhance the effectiveness of psychotherapy. The second, a study by Alladin and Alibhai (2007), inquired specifically about the use of CH as an effective treatment modality for clinical depression. A review of the Alladin and Alibhai study follows.

Alladin and Alibhai's (2007) study included 98 participants who met the criteria for chronic major depressive disorder based on the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000). The subjects were randomly assigned CH or cognitive behavioral therapy (CBT) treatment groups. Participants were exposed to 16 weeks of outpatient treatment. Follow-up procedures were implemented at 6-month and 12-month intervals. Effect size in the CH group showed significant reductions in symptoms related to depression, anxiety, and hopelessness. Improvements were maintained at 6-month and 12-month follow-up. The authors concluded by suggesting the addition of CH to CBT has the potential to enhance CBT.

In searching the literature, the Alladin and Alibhai (2007) study appears to be the only controlled empirical research comparing CH with CBT in the treatment of depression in the past 10 years. This is surprising considering current estimates from the World Health Organization (WHO), which indicate that depression affects approximately 350 million people worldwide (WHO, 2016). To further complicate matters, there is often a comorbidity between depression and anxiety (American Psychiatric Association, 2013; McLaughlin & Nolen-Hoeksema, 2011; Yapko, 2010). Recent data from the National Institute of Mental Health report that, in the United States, 18% of adults and 46% of children between 13 and 18 years old struggle with some form of anxiety (NIMH; 2016a, 2016b). In response to the prevalence of anxiety and depression, the World Health

Assembly passed a resolution calling for a “comprehensive, coordinated response” to mental health disorders (WHO, 2016, p. 1). Although there are effective interventions and pharmacotherapies to treat depression and anxiety, less than half of those seeking help for these disorders receive adequate care (Alladin, 2010; NIMH, 2016a; NIMH, 2016b; WHO, 2016; Yapko, 2010).

### **Clinical Hypnosis and CBT**

In the field of CH, researchers contend that combining CH with CBT is a natural union, particularly considering the emerging demands of health care requiring cost containment, evidence-based practice, measurable outcomes, and effective brief interventions (Alladin & Alibhai, 2007; Alladin, Sabatini, & Amundson, 2007; Lynn, Kirsch, Barabasz, Cardena, & Patterson, 2000; Schoenberger, 2000; Yapko, 2010). In general, CBT focuses on increasing awareness of internal thoughts (cognitions) while learning techniques to restructure unhelpful thoughts. With CBT, the client/patient is taught strategies such as positive self-talk and thought stopping, with the objective of increasing self-control and mastery over problem behaviors (Frew & Spiegler, 2013). Interestingly, in their text, Frew and Spiegler (2013) pointed out that although thought-stopping techniques are considered a cornerstone of CBT, there is limited empirical research supporting the efficacy of thought-stopping techniques.

Kirsch et al. (1995) used a meta-analysis study design to explore the benefits of integrating CH into a standard CBT protocol. Kirsch et al. analyzed 18 studies involving 577 participants over a 20-year period from 1974 to 1993. The sample included clinical patients, college students, or a combination of the two populations. In the study, subjects were assigned to treatment randomly and sequentially. The construct for analysis was the treatment modality CH + CBT or CBT alone. The effect size for each outcome variable was calculated. Limitations of the studies included lack of a clear definition for treatment and no clarity about who was providing the treatment. Strengths of the study include a comparison of 577 participants, effect size calculation to measure between group differences, and in some cases, a post-treatment follow-up of 2 years. In their discussion, Kirsch et al. found that CH, when used in conjunction with CBT, increased the efficacy of CBT.

Researchers Otte (2011) and Kaczurkin and Foa (2015) reviewed the empirical evidence supporting CBT as an effective treatment for anxiety disorders. Interestingly, both authors found limited empirical research supporting CBT as the gold standard for the treatment of anxiety disorders. Otte explored the efficacy of the research specific to the treatment of generalized anxiety disorder (GAD). During her review, Otte found two studies using a randomized controlled design—the gold standard for empirical research. Although Otte acknowledged the limited amount of empirical research, she concluded her study by positioning CBT as the “gold standard” in the treatment of anxiety disorders (p. 420). Interestingly, the use of imagination and relaxation techniques are recognized as part of cognitive behavioral protocols; however, neither Otte nor Kaczurkin and Foa suggested the possibility of adding CH as an adjunct therapy to enhance CBT.

Alladin (2010) considered CBT to be the yin to hypnosis’ yang. CH and CBT both utilize relaxation and imagery; CBT and CH are both fundamentally eclectic and easily integrated into an array of counseling techniques. CBT focuses on cognitive restructuring, while CH targets deeper unconscious processing, reframing, and insight.

Furthermore, CBT provides a solid theoretical background universally familiar to most mental health professionals. CH and CBT are multimodal approaches that are both effective in the treatment of a variety of mental and physical health conditions (Alladin, 2010; Alladin & Alibhai, 2007; Golden, 2012). See Table 1 for a side-by-side comparison of CH and CBT.

Table 1

*A Brief Side-by-Side Comparison of Hypnosis and CBT*

CBT	Clinical Hypnosis
Focus on conscious restructuring	Focus on unconscious reframing
Reasoning & Socratic questions/discussion	Suggestion, metaphors, double binds
In vivo use of prompting, reinforcing, modeling	Use of imagination, future, past, and present
Thought stopping, reframing, practice	Relaxation, induction, suggestion, ego-strengthening

*Source:* Alladin and Alibhai (2007); Golden (2012)

### **Hypnosis and Relaxation**

Relaxation techniques are known to be beneficial in the treatment of anxiety, depression, and general stress reduction (Alladin, 2010). Relaxation is the process of slowing the autonomic response to stress. An example of a common relaxation technique would be to find the breath and simply notice the rhythmic motion of the inhale and exhale. CH routinely follows a general protocol that includes relaxation, induction, suggestion, and ego-strengthening (Alladin & Alibhai, 2007; Lynn & Kirsch, 2014). In CH, relaxation is used as a means of transitioning the client to an altered state of focused concentration, where suggestions can be made.

Suggestion is an important component of CH. Suggestion coupled with an altered state of consciousness can result in a powerful intervention. Suggestion separates CH from relaxation, guided imagery, and mindfulness (Lynn & Kirsch, 2014). Generally, suggestions are crafted to fit the client's needs, goals, and personality and suggestions are delivered through metaphors, imagery, or narratives (Lynn & Kirsch, 2014). Here is an example of a script for suggestion in a CH session:

Each time throughout the day you encounter a situation or a sensation where the meaning is not clear to you, or you can even anticipate such an event before it happens, you can remind yourself that there are many different ways to interpret the event . . . you may also, instantly and automatically, remind yourself you don't know what it means just yet . . . but you can entertain a variety of interpretations . . . and you may ask yourself directly how you will know which interpretation, if any, is a correct one . . . which one is most helpful, reassuring, and accurate. (Jensen, 2011, p. 172)

## **Clinical Hypnosis and the Medical Profession**

There is a large body of literature supporting the use of CH as an adjunct therapy for the treatment of pain and gastrointestinal (GI) disorders (Bremner, 2013; Jensen, 2011; Palsson & van Tilburg, 2015; Patterson, 2010; Spiegel & Bloom, 1983). Moreover, both conditions are prevalent in primary care and behavioral health, frequently presenting with comorbid anxiety and depression (WHO, 2016).

### **Clinical Hypnosis and Pain**

In his book, *Clinical Hypnosis for Pain Control*, clinical psychologist Patterson (2010) cited over 50 studies investigating the use of CH to treat pain, ranging from chronic cancer pain to the acute pain of burn victims. Patterson also examined some of the challenges in the research, which include small sample sizes, lack of control groups, and questions about confounding variables. Nonetheless, Patterson maintained that the research consistently demonstrates CH has greater efficacy in the treatment of pain when compared to placebo or standard protocol.

### **Clinical Hypnosis and IBS**

Researchers Palsson and van Tilburg (2015) developed a scripted treatment protocol using CH and guided imagery to treat irritable bowel syndrome. This script is known as the Irritable Bowel Syndrome Hypnosis (IBSH) protocol. The IBSH protocol is administered bi-weekly over a 3-month period with a take home audio component for consistent reinforcement. The hypnotic suggestions in the IBSH protocol include: (a) suggestions for minimal attention to GI symptoms, (b) suggestions for reframing the lived experience of the GI distress, (c) suggestions for a sense of well-being, (d) suggestions to block future GI discomfort, and (e) suggestions for regular comfortable bowel/GI performance.

Results indicated that, in the IBHS group, abdominal pain was reduced by 53% and stool abnormalities were reduced from 30% to 18% (Palsson & van Tilburg, 2015). This study is significant because it demonstrates that, at least for IBS, (a) CH can be delivered effectively with a scripted protocol by a health care professional in a clinical setting, and (b) CH can be manualized to fit a standard treatment format.

## **Clinical Hypnosis and the Counseling Profession**

Professional counselors graduating from accredited counselor education programs bring a solid foundation of important skills to the table. At the master's level, clinicians demonstrate counseling skills, which include the ability to establish rapport; facilitate communication; attend and listen with positive regard; and integrate, interpret and summarize complex presenting information such as diagnosis and medical, emotional, and family history. These skills are also important foundational skills required for the effective use of CH.

Clinical hypnosis and professional counseling share similar philosophies centered around strengths and wellness, solid ethical and professional practice, and values, including cultural competency and diversity (Ivey, Zalaquett, & Ivey, 2009; Otani, 1989; Yapko, 2010). Although CH is generally not part of the conversation in counselor



education programs, CH is compatible with popular counseling techniques such as CBT. Additionally, CH could easily be integrated into counseling sessions (Alladin, 2010; Daitch, 2007; Gunnison, 1990; Yapko, 2010; Zahourek, 2002). Furthermore, Ericksonian counseling principles are incorporated early into the professional counselor's training. These principles are evidenced in the micro-skills of attending, observing, encouraging and paraphrasing, focusing, and reflecting (Ivey et al., 2009). These skills are also important foundational skills required for the effective use of CH.

A brief example follows of a four-phase treatment protocol for anxiety that integrates CH and CBT with the skill set of the professional counselor (protocol adapted from Alladin, 2016).

Phase I: Assessment, case conceptualization, and rapport building. This includes a detailed biopsychosocial history, goal setting based on the unique needs of the client, and the establishment of a safe, non-judgmental therapeutic environment.

Phase II: Enhancing and encouraging self-efficacy, symptom management, teaching and practice of hypnotic and CBT interventions such as relaxation training, mind body/body mind awareness, ego-strengthening, and thought stopping.

Phase III: Client has improved, demonstrates increased self-confidence and decreased anxiety evidenced in global measures (thoughts, affect, behaviors), goals are met

Phase IV: For clients with improvement who want deeper exploration of the roots of their symptoms, treatment can continue with advanced hypnotic techniques, such as the affect bridge, a method of moving back in time to an initial memory, sensation, or experience (Watkins & Watkins, 1997).

As a caveat, as with any specialized counseling technique, the appropriate training is a vital part of professional, clinical, and ethical practice. Basic competence in CH would include, at minimum, a 20-hour training from a professional organization specializing in CH (ASCH, 2013). As with any ongoing education endeavor, staying current with the literature, ethical codes, and credentialing process to ensure professional standing is recommended.

In order to assist counseling students explore CH as a viable clinical intervention, counselor education programs could: (a) incorporate an overview of CH in theories and techniques courses, (b) offer elective courses covering the basic skills, competence, and ethics required to apply CH in clinical practice, (c) expand library access to include electronic access to flagship journals dedicated to the study of CH, and (d) advocate for scholarly discourse and research in professional counseling journals, such as the *Journal of Counseling and Development*.

## **Conclusion**

This paper begins to provide a rationale for the integration of CH into the counseling professional's toolkit. Literature has been presented debunking some of the criticisms and concerns surrounding the use of CH as an effective clinical intervention for the treatment of depression, anxiety, IBS, and pain management. Recommendations

include the development of evidence-based interventions and protocols, along with future inquiry for the use of CH or the combination of CH and CBT.

In summary, CH as a stand-alone intervention or integrated with techniques such as CBT has the potential to generate new evidence-based interventions that (a) can be applied to a diverse range of ages, cultures, disorders, and settings, (b) are structured enough to be manualized for managed care environments and third party insurance payers, (c) offer person-centered, strengths-based interventions, and (d) honor the ethical and professional standards of the counseling profession.

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