ON THE NEED TO REGULATE THE USE OF HYPNOSIS IN VIRGINIA

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(The following article is a copy of Dr. Wickram's testimony before the Council on Health Regulatory Boards on May 4th, 1987. Anyone desiring a copy of the references cited here may make a request in writing to the Editor.)

I would like to accomplish two goals in this testimony. First, to demonstrate that there is today enough scientific and technical knowledge accumulated about hypnosis to reveal it to be a procedure and phenomenon of sufficient potency and reliability to have broad uses in psychological and biological health care (Hilgard, 1965; Barber, 1969). Second, to point out that the induction technique per se is easily learned, but that its applications to psychology and medicine are much more complicated; therefore, there is serious potential, in unskilled hands, for the unintentional production through hypnosis of psychopathology and pathology. In other words, hypnotic induction per se is like a sharp knife or an empty syringe: anybody can pick up a knife or syringe, but what to put into the syringe or how to use the knife in surgery is a function of professional training in surgery and medicine. Hence, hypnosis can result in mental serenity or anxiety, or in healing or trauma.

First, in terms of the scientific and professional recognition of hypnosis, let me begin by pointing out that it is a matter of historical fact that the British Medical Association, in 1955, was the first to recognize that there was a sufficient body of scientific knowledge accumulated about hypnosis to go on record recommending the teaching of hypnosis in medical schools and its cautious use in medical practice. In 1958, the American Medical Association made a similar recommendation. In 1960, the American Psychological Association gave official recognition to a certifying board, The American Board of Examiners in Psychological Hypnosis. The Society for Clinical and Experimental Hypnosis was established in 1947 and the American Society for Clinical Hypnosis was established in 1957. Membership in both societies is limited to those who have earned their doctorate in behavioral, medical, or dental sciences.

I would like now to review briefly in outline what is known about hypnosis through controlled and independently replicated empirical observations, as opposed to clinical lore and theoretical speculations. First, if anything exists, it should exist in a known quantity and should be measurable. Tests of hypnotic behavior like the Harvard, Stanford, and Barber Scales have shown hypnotic ability to be measurable, normally distributed, stable, and partly genetically determined (Hilgard, 1965; Barber, 1969).

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Approximately 90% of the population are hypnotizable to some degree. Approximately 15% of the population have superior hypnotic ability. Positive motivation alone is an essential, but insufficient, condition to demonstrate superior hypnotic control of psychological or physiological functions. Hypnotic ability has been found to be modestly and positively correlated with IQ and creativity, and modestly and negatively correlated with psychopathology. Hypnosis can be defined as a procedure through which changes ranging from mild to profound can be induced in the perception, memory, and mood of select subjects. These psychological changes can have major behavioral and biological consequences. These changes include positive and negative
hallucinations in all sensory modalities, the facilitation or inhibition of muscular responses, anesthesia and analgesia, facilitation and inhibition of memory, alterations in meaning, emotion, and images of self, as well as very specific or general physiological changes in heart rate, blood pressure, skin conductance, blood flow, skin temperature, and glandular secretions (Hilgard, 1965; Barber, 1984), etc. Hypnosis can produce effects that are more specific than the effects of drugs. For example, one study done at Stanford Medical School (Maslach, Marshall, and Zimbardo, 1973) demonstrated that people can be trained to warm one hand and to concurrently cool the other hand. I know of no drug on the market that can do this. All of the above psychophysiological phenomena can produce, in people who have hypnotic ability (90% of the population), inadvertently, both psychopathology (e.g., phobias, anxieties, depressions, and temporary psychotic symptoms like hallucinations and delusions) and pathophysiology (e.g., hypnotic analgesia used to block the headache pain due to a brain tumor or the backache due to a herniated disc). Hypnosis can be used to block physical symptoms which require medication or surgery and to mask psychological symptoms that require psychotherapy.

At a strictly observational or descriptive level (what phenomena can be produced), there is agreement among all scientific investigators of hypnosis; however, there is some disagreement at the level of explanation or theory as to why these psychological or physiological changes occur in people during hypnosis. Typically, these changes in psychological and physiological functions induced through hypnosis can be readily reversed, but, in some instances though, particularly when the hypnotized person is: i) latently or actively emotionally disturbed; or when 2) hypnosis may inadvertently reactivate a prior traumatic experience unknown to the hypnotist, or 3) when the hypnotized person has financial, legal, interpersonal, or social incentives, the psychological or physiological changes produced by hypnosis may persist or even increase (Hilgard, 1965; Wickramasekera, in press). Recognition and immediate management of such emergencies require professional training.

There is also growing evidence (Wickramasekera, 1986, in press) that people who are higher on hypnotic ability are at greater risk for the development of certain psychological and psychophysiological disorders (e.g., phobias, post-traumatic stress disorders, bulimia, multiple personality and psychophysiological disorders). Hence, it is precisely that group of people for whom hypnosis has the greatest potential for good for whom it also has the greatest potential for harm if hypnosis is mismanaged. The

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management of hypnosis in superior hypnotic subjects clearly requires professional training beyond training in hypnotic induction techniques per se. Unless one has had supervised training in both hypnotherapy and in the recognition and management of psychopathology, psychodynamics, and psychotherapy, etc., one should take the Pinto (counseling or psychotherapy) and leave the Masserati (hypnotherapy) at home. Collision in such a high speed car can be messy. Training as a psychologist, physician or dentist alone is an essential, but insufficient, condition for the effective practice of clinical hypnosis.

In regard to the use of hypnosis to enhance eye-witness testimony, it is now well-established (American Medical Association position paper, 1985) by numerous scientific
studies that: 1) even experts in hypnosis cannot distinguish fact from fiction in hypnotically elicited testimony and that expecting a lay jury to do so is unreasonable, 2) hypnotic procedures, by increasing suggestibility, increase witness self-confidence in both fact and fantasy in their testimony, 3) hypnosis often leads to more inaccurate recall than can be obtained without hypnosis, and 4) the hypnotized individual is more susceptible to accepting misinformation or hypnotist bias, and tends to incorporate it into his own prior memory. Use of either the Orne guidelines (1978) or the FBI guidelines can protect the use of hypnosis from the above pitfalls. These guidelines recommend that:

1) The hypnosis should be done by a psychologist or psychiatrist who is specifically trained in hypnosis, 2) all interaction between professional and witness should be videotaped with no others in the room, 3) hypnosis should be used to enhance memory only in situations where there is independent evidence to verify or corroborate the witness testimony.

Without the use of such guidelines, testimony elicited under hypnosis is inadmissible in court in several states in the U.S. and, from the viewpoint of opposing counsel, what has happened to the witness under hypnosis is a destruction of evidence.

Unfortunately, due to the abuses of hypnosis in the area of enhancing memory of eye-witness testimony, at least 15 states' Supreme Courts have prohibited the use of hypnosis to enhance memory in courtroom testimony (e.g., People vs. Shirley, 1980; State vs. Mack, 1980; and People vs. Kempinski, 1980). Had proper regulation existed based on the Orne or FBI guidelines, "the baby may have not been thrown out with the bath water." We need such regulation both in the area of health care and in the criminal justice field to prevent losing "the baby with the bath water" in Virginia. Like any other potent technology (e.g., drugs), hypnosis has potential for both good or evil. Restrictions based on credentials will not guarantee that hypnosis will not be abused in Virginia, because credentials do not guarantee competence, but credentials at least guarantee a minimum level of incompetence in the conduct of human affairs.

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Efforts Toward State Hypnosis Network/Association Under Way

Efforts are now under way to develop a state-wide network or formal association for appropriate practitioners of hypnosis. The potential core for a state hypnosis group now exists in the Charlottesville Hypnosis Interest Group, which has now been meeting on the third Tuesday evening of the month for over a year and a half, and is directed by Joe Dane, Ph.D., of the Department of Anesthesiology Pain Management Center, UVA Medical School in Charlottesville. In an effort to draw together practicing hypnotherapists from around the state, Dr. Dane has arranged for
References


State Vs. Mack, (1980); Minn. 292 N.W. 2nd 764.

