Standards of Training in Clinical Hypnosis

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American Society of Clinical Hypnosis—Education and Research Foundation
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INTRODUCTION

The quality of hypnosis training in North America has been variable. The curriculum in hypnosis workshops and courses conducted outside of major training organizations has sometimes had a haphazard quality rather than systematically surveying vitally important principles and areas of knowledge. This publication provides the professional community with relevant information regarding minimum standards of educational preparation for the clinical practice of hypnosis with medical, psychological and dental disorders. Also presented is the training curriculum recommended by the American Society of Clinical Hypnosis as required to adequately prepare clinicians for using hypnosis in practice.

The Standards of Training are presented as a flexible guideline and not as rigid curricula. The American Society of Clinical Hypnosis envisions that course developers and faculty will view these Standards as a starting point, and cover material on clinical hypnosis in ways that accommodate their own expertise, teaching style, and program structures.

Included in this volume will be the requirements for ASCH Certification in Clinical Hypnosis and for attaining the status of ASCH Approved Consultant in Clinical Hypnosis. Qualified professionals who are accepted for ASCH certification are recognized as meeting all of the training requirements. ASCH Approved Consultants in Clinical Hypnosis have met all the requirements for certification, and in addition have completed advanced training. Following completion of educational course work, applicants for certification are required to have concluded a minimum of twenty (20) hours of individualized training with a learning contract through an ASCH Approved Consultant. A list of ASCH Approved Consultants may be obtained from the ASCH administrative office.

Certification in clinical hypnosis by ASCH means that the practitioner has completed fundamental educational training. All workshop training must be approved by the ASCH Standards of Training Committee to be accepted by ASCH toward certification and membership requirements. A listing of ASCH approved training is maintained by the ASCH administrative office. A model curriculum and educational objectives for beginning and intermediate workshops or courses is presented. The practice of clinical hypnosis, like psychotherapy, is not an exact science. Therefore, a blend of scientific research and clinical skills and methods is found in the approved model curriculum. This curriculum has been accepted by the ASCH Executive Committee, and was guided by the results of an extensive survey of 111 international authorities in the field of clinical hypnosis. This document represents an effort to improve the standards of training in the field of clinical hypnosis. These standards will
be periodically reviewed and updated.

The highest standards of professional conduct and ethics are emphasized in all aspects of training, with specific time devoted to these topics. The ethical standards of the American Society of Clinical Hypnosis are also provided in this volume.

In regard to additional training resources, an extensive recommended reading list is included. The reader will also find a listing of the recognized specialty boards in hypnosis in the professions of medicine, psychology, dentistry, and social work. Successful completion of diplomate board examinations represents the highest level of certification and denotes the attainment of advanced skill competency. We encourage all practitioners, following certification, to work toward diplomate status.

ASCH initiated the program of Certification in Clinical Hypnosis on January 1, 1993, following the recommendations of the Standards of Training and Certification Task Force after a year and a half of study. Members of the task force were D. Corydon Hammond, Ph.D., ABPH, Chair, Gary R. Elkins, Ph.D., Richard P. Kluft, M.D., Ph.D., William C. Wester, II, Ed.D., ABPH, Charles B. Mutter, M.D., ABMH, Thurman Mott, M.D., ABMH, and Simon Rosenberg, D.M.D., ABHD. A special thanks is extended to those dedicated individuals and to Richard W. Rasche, Ph.D., Chair of the Membership Committee.

CERTIFICATION PHILOSOPHY

The American Society of Clinical Hypnosis certification program is designed to provide a nonstatutory, voluntary credentialing program for licensed and qualified physicians, psychologists, osteopathic physicians, podiatrists, dentists, chiropractors, doctoral level social workers and nurses, and masters degree level social workers, psychologists, nurses, marriage and family therapists, speech-language pathologists, and mental health counselors who use hypnosis in their clinical work. Accreditation by the American Society of Clinical Hypnosis certifies that the practitioner has met fundamental educational training requirements in clinical hypnosis.

Certification does not automatically imply competence or guarantee the quality of a practitioner’s work. It does indicate, however, that the practitioner: 1) Has undergone advanced professional training in his/her profession to obtain a legitimate advanced degree from an accredited institution of higher education; 2) Is licensed in his/her state or province, or certified in his/her profession; 3) Has had his/her education, training and skills in clinical hypnosis reviewed by qualified peers and approved consultants; and 4) Has been determined to have received the minimum educational training that the ASCH, the largest such interdisciplinary professional organization in North America, considers as necessary for utilizing hypnosis.

Certified individuals are bound by the ethical codes of their professions and licensure statutes. They are also bound by the ASCH Code of Conduct. They have also committed that they will only use clinical hypnosis in the treatment of conditions that they are ethically qualified to treat by virtue of their licensure and non-hypnotic professional training.

The American Society of Clinical Hypnosis certification program is an entry level credentialing program in hypnosis that is restricted to legitimately trained and licensed health and mental health professionals with advanced degrees. It is our philosophy that persons trained in only hypnosis lack the diagnostic and therapeutic skills, as well as the licensure required to safely and responsibly treat medical, psychological, or dental problems with hypnosis.

Credentialed practitioners are encouraged to work toward attaining the highest level of advanced specialty certification in hypnosis through obtaining diplomate status from either the American Board of Medical Hypnosis, the American Board of Psychological Hypnosis, the American Board of Hypnosis in Dentistry, or the American Hypnosis Board for Clinical Social Work.
**STANDARDS FOR THE CONTENT OF WORKSHOPS & COURSES**

We believe that the following topic areas and amounts of time should represent the minimum standard for beginning and intermediate workshops and courses in clinical hypnosis. The required topic areas identify the specific learning objectives that must be met in the training. However, these learning objectives may be met within a variety of educational formats and educational experiences. Individuals seeking ASCH Certification in Clinical Hypnosis are required to complete approved beginning and intermediate level workshops, with qualified trainers, that meet these standards of training.

**Beginning Workshop Curriculum**

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<thead>
<tr>
<th>Required Topic Areas</th>
<th>Minimum Time Recommended (Mins.)</th>
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<tr>
<td>1. Definition, History, and Theories of Hypnosis</td>
<td>40</td>
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**Recommended Learning Objectives:**
A. Provide a definition of hypnosis related to relevant scientific research.
B. Outline major historical events in hypnosis and mesmerism.
C. Discuss major theories of hypnosis including neo-dissociative, social psychological, psychodynamic, social learning or expectancy, the Ericksonian atheoretical approach, and multifactor or multidimensional formulations.

**Recommended Content:** It is recommended that discussion of history may profitably include discussion of Mesmer and the Royal Commission; Marquis de Puységur (artificial somnambulism); di Faria ("lucid sleep," concentration rather than animal magnetism, involuntariness, father of suggestion theory, importance of the subject rather than the hypnotist); Elliotson and Esdaile (hypnoanesthesia for surgery); James Braid (term "hypnosis" and movement away from mesmeric passes toward relaxation and suggestibility); Liebeault and Bernheim (hypersuggestibility theory; Nancy School emphasis of hypnosis as a psychological, not psychopathological state); Charcot (the Salpetriere; hypnosis as a psychopathological, hysterical process); Janet (dissociation theory and the subconscious); Freud and Breuer (abreaction with conversion symptoms; abandonment of hypnosis for free association); formation of SCEH and ASCH; and Milton H. Erickson’s work.

Given the diverse theories and research evidence, we believe it most wise and prudent to view a multiplicity of factors as playing a role in hypnotic response, and for instructors to provide an even-handed reference to the diversity of current theories. Therefore, discussion of theories should indicate that hypnotic response is most likely a multidimensional, multicausal phenomenon involving some varying combination and reciprocal interaction between several possible factors, including: a) Heredity and physiological factors (e.g., likely involving the limbic structures of the amygdala and hippocampus, possibly ultradian rhythms, and possibly associated with theta brainwave patterns and an inhibition of left hemisphere activity and an increase in right hemisphere dominance) (e.g., see work by DeBennedictis, Crawford, Grzueller, Rossi, Spiegel). b) Dissociative processes (e.g., Hilgard, Watkins, Bowers, Kihlstrom, Janet). c) Absorption in imagery (e.g., capacity for and quality of imaginative involvement, imagining "as if," absorption and concentration of attention with a fading of generalized reality orientation, often experienced subjectively as an altered state of consciousness) (e.g., J. Hilgard, Tellegen, Orne, Shor). d) Cognitive-motivational and social psychological variables (e.g., expectations, attitudes, motivations, compliance, desire to please, demand characteristics, suggestibility, contextual cues, cognitive strategies and interpretational sets, role taking or "thinking as if," and psychological regression (e.g., T. X. Barber, Spanos, Kirsch, Council, Sheehan, McConkey, Diamond, White, Coe and Sarbin, Fromm, Nash). e) Interpersonal-environmental variables (e.g., quality of relationship, perceived competence, trust, transferential components and depth of archaic involvement, conducive environment, and environmental variables which might include such factors as early childhood physical or sexual abuse, posttraumatic stress disorder, sensory restriction or deprivation, and childhood permission for imaginative involvement (Kubie and Margolin, Gill and Brenman, Shor, Barabasz).

2. Myths and Misperceptions of Hypnosis: Hypnosis and Memory 30

**Recommended Learning Objectives:**
A. Identify the major myths and misconceptions regarding hypnosis.
B. Discuss the research on hypnosis and memory.
C. Discuss the clinical controversy regarding hypnosis and the possible creation of pseudomemory.

**Recommended Content:** It is recommended that discussion include consideration of myths and fears about loss of control and surrender of will, and loss of consciousness. It is advised that there be discussion of memory as imperfect, in or out of hypnosis. Much is still not known
and important deficiencies exist in hypnosis research. But it is known that memories retrieved through hypnosis, like memory in general, may consist of accurate information, confabulation, and inaccurate memories. Recall can improve under some conditions, and the use of hypnotic techniques may or may not contribute to that enhancement. Since hypnosis is believed by many people in the field to be a controlled dissociation and because of the evidence that many trauma and abuse victims enter trance-like, dissociative states during and after trauma, recreating an emotional and dissociative context through hypnosis may facilitate both the recovery and working through of traumatic memories. Traumatic memory may be encoded differently than normal memory. Abundant evidence suggests that traumatically-induced amnesia exists. Increasing evidence supports the existence of delayed memory or so-called robust repression. But, if not used cautiously, hypnotic procedures can increase false confidence, likely from suggestion effects that create expectations that there will be accurate recall. Thus, pre-hypnotic and hypnotic suggestions must create a neutral atmosphere concerning whether or not further information or accurate information will be revealed. Because persons may be led to change perceptions or create pseudomemories through questioning either in or out of hypnosis, clinicians must always work cautiously and avoid leading patients. High hypnotizable subjects, whether or not hypnosis is used, appear more prone to developing pseudomemories. But it also appears that subjects may often be capable of distinguishing preexisting memories from pseudomemories. Currently there is no litmus test that allows anyone to know whether a memory is relatively accurate, confabulated, or distorted, in the absence of corroborating evidence. Patients must therefore be cautioned that if they consider confronting alleged perpetrators of abuse, their unsubstantiated memories, no matter how vivid or emotional may lack sufficient weight in a court of law. Students should receive a copy of the 1994 ASCH guidelines for clinicians in working with hypnosis and memory in cases involving possible abuse, and should be aware of the existence of forensic guidelines.

3. Assessment, Presenting Hypnosis to the Patient, and Informed Consent

Recommended Learning Objectives:
A. Be capable of discussing hypnosis in a non-technical manner with a client or patient.
B. Review important elements in obtaining informed consent regarding the use of hypnosis clinically.

Recommended Content: Standard psychological or medical evaluation of patients and diagnostic clarity should be established prior to using therapeutic hypnosis. It is believed that valuable constructs in presenting hypnosis to patients may include the concept that all hypnosis is really self-hypnosis, the concept of the everyday trance and the commonness of absorption experiences, and that persons possess hypnotic talents for experiencing various hypnotic phenomena. Informed consent should acknowledge the use of hypnotic techniques rather than identifying hypnosis by a synonym; discuss the imperfection of memory and need for corroboration of hypnotically obtained memories; and acknowledge that a person who has been hypnotized may not be able to testify in court about anything remembered during or after the hypnosis. Thus, the only way to fully protect their potential right to testify is to forego the use of hypnosis if they believe that there is some reason to anticipate that memories retrieved by hypnosis might have legal consequences.

4. Hypnotic Phenomena and Their Therapeutic Applications

Recommended Learning Objectives:
A. Define and be aware of research on phenomena associated with hypnosis.
B. Provide illustrative suggestions for eliciting hypnotic phenomena.
C. Discuss and illustrate the concept of trance logic.
D. Illustrate applications of hypnotic phenomena in clinical cases and treatment planning.

Recommended Content: It is urged that discussion include ideomotor phenomena (e.g., hands moving together, arm lowering, eye closure, ideomotor signals, passive arm catalepsy, levitation, and inhibition of voluntary control such as automatic movements, finger lock, eye catalepsy, and limb rigidity or immobilization), ideasensory activities, dissociation, analgesia and anesthesia, hypnotic dreams, posthypnotic suggestions, hypermnesia and age regression (partial regression and revivification), amnesia, time distortion, the hidden observer or ego-state phenomena, and negative and positive hallucinations (olfactory, gustatory, kinesthetic, auditory, or visual). It is suggested that students learn the relative frequency (difficulty level) with which different hypnotic phenomena may be facilitated, and understand “the classic suggestion effect” of experiencing phenomena with a sense of involuntariness.
### Required Topic Areas

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<th>Required Topic Areas</th>
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**Recommended Learning Objectives:**

A. Identify steps in facilitating hypnotic induction.
B. Discuss the importance of removing suggestions and realerting patients, and be able to verbalize at least one method for realerting from hypnosis.
C. Identify and define at least 6 principles of hypnotic induction and suggestion.
D. Describe at least 4 types of hypnotic suggestions.

**Recommended Content:** The process or steps in facilitating induction should be discussed (e.g., preparing and educating the patient, fixation of attention and deepening involvement, facilitating involuntary or unconscious response, realerting) along with the importance of removing suggested effects and techniques for realerting. It is advised that content also include emphasis of the importance of establishing rapport and a cooperative relationship, and discussion of the following principles: creating positive expectancy; the law of reversed effect or effort; the law of dominant effect; the law of concentrated attention; the principle of using positive suggestions; the principle of trance ratification; and the value of careful observation, and Erickson’s principle of individualization and utilization of patient interests, needs, personality, talents and motivations. We urge instructors to review research documenting the overall lack of superiority for direct versus permissive or indirect suggestions. It is further encouraged that students be introduced to several types of hypnotic suggestions such as truisms and contingent suggestions, including indirect suggestions such as the use of questions, implication, covering all possibilities of response, interspersing suggestions, use of analogies or metaphors, and types of double binds. Illustrations of some of these styles of suggestions in facilitating hypnotic phenomena may be given.

### 6. Demonstrations of Hypnotic Inductions

**Recommended Learning Objectives:**

A. Students should be familiar with demonstrations and able to identify how to facilitate at least 4 basic induction techniques.

**Recommended Content:** It is suggested that beginning, basic inductions may most profitably include fundamental ideomotor inductions (e.g., arm drop, hands moving together, the coin technique, or Chiasson’s technique because they require very limited hypnotic ability. Therefore, they are relatively fail-safe and have high probabilities of success, as well as containing trance ratification properties), progressive relaxation, imagery, eye fixation, or eye roll inductions. Educators are encouraged to demonstrate and then discuss the fine points involved in facilitating the induction methods.

### 7. Demonstration or Video Demonstration of Eliciting Hypnotic Phenomena

**Recommended Learning Objectives:**

A. Students should have observed a demonstration, either live or through a videotape, so that they can identify at least 5 or 6 of the phenomena associated with hypnosis (identified in topic 4).

### 8. Supervised Small Group Practice of Hypnotic Inductions

**Recommended Learning Objectives:**

A. Each participant should have an opportunity to participate as a hypnotic “subject” in 3 separate experiences, personally experiencing to the degree they are capable, hypnotic inductions and phenomena.

B. Each participant should have at least 3 opportunities to serve as a facilitator of hypnosis for another person, demonstrating the ability to facilitate 3 different hypnotic induction techniques, and to suggest some hypnotic phenomena.

**Recommended Content:** It is recommended that supervisors do not demonstrate inductions or answer questions during this time. This time should be strictly reserved for experiential student practice, with supervisors providing feedback and brief modeling of alternative verbalizations. The recommended ratio of faculty to students is one supervisor for every 6-8 student participants in small group practice sessions.


**Recommended Learning Objectives:**

A. Identify that there is evidence for the long term stability of hypnotic responsivity, suggesting possible genetic and trait (e.g., dissociative) involvement, but that there is also support that situational-contextual variables are involved in hypnotic response. No one theory or single variable accounts for responsiveness.

B. Be able to discuss the controversy about whether hypnotic responsivity is modifiable, or whether such efforts merely produce
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<th>Required Topic Areas</th>
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<tr>
<td><strong>10. Self-Hypnosis: How and What to Teach Patients</strong></td>
<td>45</td>
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<td><strong>Recommended Learning Objectives:</strong></td>
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<tr>
<td>A. Define self-hypnosis.</td>
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<tr>
<td>B. Be capable of teaching self-hypnosis to patients.</td>
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<tr>
<td>C. To identify therapeutic applications of self-hypnosis in clinical practice.</td>
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<tr>
<td><strong>Recommended Content:</strong> It is urged that students be shown how self-hypnotic induction cues may be established through posthypnotic suggestion and in-session practice. The value of individualized audiotapes, and applications with medical conditions (e.g., pain, hyperemesis, asthma, gastrointestinal problems, wound healing) and psychiatric problems (e.g., anxiety disorders, for ego-strengthening, sleep disorders, sexual dysfunction) should be explained.</td>
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<tr>
<td><strong>11. Treatment Planning, Strategy and Technique Selection in Hypnotherapy</strong></td>
<td>60</td>
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<td><strong>Recommended Learning Objectives:</strong></td>
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<tr>
<td>A. Illustrate clinical conditions where one may begin with a suggestive hypnotic approach versus an insight-oriented or exploratory hypnotic approach.</td>
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<td>B. Indicate cases where hypnotic techniques may be indicated or relatively contraindicated.</td>
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<td>C. Demonstrate understanding of the different types of strategies or therapeutic goals to which hypnotic techniques may be applied.</td>
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<td><strong>Recommended Content:</strong> It is recommended that students be introduced to variables that may be taken into account in hypnotic treatment planning and technique selection, such as symptom complexity and intensity, level of hypnotic talent and responsivity, patient expectations or preferences, degree of psychological-mindedness and impulse control, personality or dominant defensive coping style, diagnosis, stage in the change process, quality of the therapeutic relationship, degree of resistance and locus of control. Techniques where hypnosis may be used in the service of therapeutic strategies or goals such as enhancement of insight, abreaction or emotional facilitation, perceptual change, reduction or alteration of affect, facilitation of behavioral change, and facilitation of physiological change may also be illustrated.</td>
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<tr>
<td><strong>12. Strategies for Managing Resistance to Hypnosis</strong></td>
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<td><strong>Recommended Learning Objectives:</strong></td>
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<tr>
<td>A. Demonstrate awareness of therapist, patient, and environmental variables that may contribute to resistance.</td>
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<tr>
<td>B. Identify at least 6 alternative techniques for bypassing or working through resistance to hypnosis.</td>
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<td><strong>Recommended Content:</strong> In addition to discussing sources of resistance, it is recommended that specific methods for working through resistance be discussed and/or illustrated, such as: educating patients about myths and misconceptions about hypnosis; separating hypnosis from the presenting problem; creating a healthy therapeutic alliance; aligning patient and therapist goals; accepting and utilizing responses of the patient; shifting to more permissive, indirect techniques; exploring the resistance consciously and with insight-oriented hypnotic techniques; obtaining the patient’s feedback, critique, and perception of what interfered with responsiveness, or use of specialized techniques such as the recall of a previous successful induction, the self-suggestion technique, the “my friend John technique” or modeling by a successful subject, or using confusional or overload techniques.</td>
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<tr>
<td><strong>13. Introduction to Hypnotic Susceptibility Scales</strong></td>
<td>30</td>
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<tr>
<td><strong>Recommended Learning Objectives:</strong></td>
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<tr>
<td>A. Demonstrate awareness of the advantages and of the limitations or disadvantages in using formal measures of hypnotic responsivity.</td>
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<tr>
<td>B. Identify the most commonly used hypnotic susceptibility scales.</td>
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<td><strong>Recommended Content:</strong> It is recommended that students appreciate that</td>
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</table>
Required Topic Areas  Minimum Time Recommended (Mins.)

formal measurement scales provide objective methods of evaluating responsivity to hypnosis and who may be more likely to derive benefit from hypnotic techniques. Such standardized measures also provide the clinician with useful information about hypnotic talents and increase practitioner confidence when seeking to facilitate hypnotic phenomena. The scales further provide modeling for clinicians in how to suggest different phenomena associated with hypnosis. However, formal scales tend to be quite directive and some individuals may respond more to an individualized or more permissive procedure. Furthermore, scales provide only one sampling of responsiveness and are not always predictive of responsiveness to hypnotic treatment. We recommend that students be aware of major instruments in this area: The Stanford Hypnotic Clinical Scales for adults and children, the Hypnotic Induction Profile, the Harvard Group Scale of Hypnotic Susceptibility, the Stanford Hypnotic Susceptibility Scale, Forms A, B, and C, and the Children’s Hypnotic Susceptibility Scale. They may also want to be aware of more purely research instruments such as the Stanford Profile Scales of Hypnotic Susceptibility, the Barber Suggestibility Scale, the Creative Imagination Scale, the Wexler-Alman Indirect Hypnotic Susceptibility Scale, and the Waterloo-Stanford Group C Scale of Hypnotic Susceptibility.

14. Ethical Principles, Professional Conduct, and Certification  30

Required Learning Objectives:
A. Describe ethical-legal issues and standards for professional conduct in using hypnosis clinically.
B. Introduce certification requirements in clinical hypnosis, and the desirability of and requirements for advanced certification through taking diplomate board examinations.

Recommended Content: We encourage discussion of ethical guidelines, the value of obtaining informed consent, adhering to guidelines and cautions in using hypnosis with exploration of memories, and in only using hypnosis to treat conditions that one is qualified to treat with non-hypnotic methods. Hypnosis should also not be used by professionals for entertainment purposes. Therapists should also be cautious because the imbalance of power created in a hypnotic encounter can tempt some therapists to cross prohibited boundaries. Students should be introduced to the major hypnosis societies, and urged to pursue advanced certification after the required time in the field by taking diplomate board examinations.

15. Integrating Hypnosis into Clinical Practice  270

The remaining four and one-half hours of workshop or course content
### Intermediate Workshop Curriculum

The following topics and training times represent minimum standards for training in clinical hypnosis for intermediate workshops or courses. Recommended learning objectives and content are presented under each topic.

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<thead>
<tr>
<th>Required Topic Areas</th>
<th>Minimum Time Recommended (Mins.)</th>
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<tr>
<td>1. Advanced and Specialized Hypnotic Inductions</td>
<td>60</td>
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<tr>
<td><strong>Recommended Learning Objectives:</strong></td>
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</tr>
<tr>
<td>A. Observe and identify or demonstrate 3 intermediate to advanced level inductions, and clarify conditions under which they may be indicated.</td>
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<tr>
<td><strong>Recommended Content:</strong> We encourage faculty to model and discuss how to facilitate more intermediate to advanced techniques such as levitation, catalepsy, the eye opening and closing, naturalistic (conversational or interactive) inductions, confusional inductions, nonverbal inductions, surprise or rapid inductions, active-alert induction, or the progressive anesthesia induction. Possible indications and contra indications may be discussed.</td>
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<tr>
<td>2. Supervised Small Group Practice of Advanced Inductions and in Facilitating Hypnotic Phenomena</td>
<td>180</td>
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<tr>
<td><strong>Recommended Learning Objectives:</strong></td>
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<tr>
<td>A. Each participant should have an opportunity to participate as a hypnotic “subject” in 3 separate experiences, personally experiencing (to the degree they are capable), hypnotic inductions and phenomena.</td>
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<tr>
<td>B. Each participant should have at least 3 opportunities to serve as a facilitator of hypnosis for another person, demonstrating 3 different intermediate to advanced level induction techniques, and suggesting some hypnotic phenomena.</td>
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<tr>
<td><strong>Recommended Content:</strong> The recommended ratio of faculty to students is one supervisor for every 6-8 students. It is recommended that supervisors do not demonstrate inductions or answer questions during this time, but reserve it strictly for experiential student practice, with supervisors providing feedback and brief modeling of alternative verbalizations.</td>
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<tr>
<td>3. Methods of Hypnotic Ego-Strengthening</td>
<td>60</td>
</tr>
<tr>
<td><strong>Recommended Learning Objectives:</strong></td>
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<tr>
<td>A. Define what is meant by ego-strengthening procedures and how they may be used in clinical practice.</td>
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<td><strong>Recommended Content:</strong> We urge faculty to teach both direct suggestion methods of ego-strengthening and more indirect or metaphorical methods through not only lecture, but also demonstration, group induction, or videotape.</td>
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<tr>
<td>4. Hypnotic Strategies and Techniques for Pain Management</td>
<td>90</td>
</tr>
<tr>
<td><strong>Recommended Learning Objectives:</strong></td>
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<tr>
<td>A. Clarify the importance of non-hypnotic methods of both medical and psychological evaluation for chronic pain patients.</td>
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<td>B. Outline precautions in using hypnotic methods for pain relief, and the limited number of conditions where one might consider creating a complete anesthesia.</td>
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<tr>
<td>C. Identify hypnotic strategies and be able to name at least 6 hypnotic techniques for use in pain management.</td>
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<tr>
<td><strong>Recommended Content:</strong> We advise instructors to emphasize the importance of thorough medical and psychological evaluation of pain problems prior to hypnotic intervention. Instruction should emphasize limitations of hypnosis and the importance of interdisciplinary treatment packages incorporating non-hypnotic and hypnotic methods. Strategies of using direct or indirect suggestions for creating analgesia (e.g., glove anesthesia, imagery modification, interspersal technique, ideomotor turn-off of pain, prolonged hypnosis), for creating cognitive-perceptual alteration of pain (e.g., dissociation, displacement of pain, replacement or substitution of sensations and reinterpretation of pain, time distortion, amnesia), distraction techniques (e.g., imagery scenes, time dissociation), and techniques for facilitating insight concerning adaptive functions or unconscious factors (e.g., ideomotor signaling, hypnoprojective techniques) may all be profitably discussed. Other useful strategies may include initiating demonstrating pain control techniques to manage acute pain that is therapist induced (e.g., using glove anesthesia), using frequent hypnotic reinforcements early in treatment, reinforcement of hypnoanesthesia prior to the exacerbation of pain and beginning by working with the least difficult or intense area of pain first when this is practical. Students should also realize the importance of leaving some “signal” pain and not creating a complete anesthesia except in limited conditions, such as with terminal illness, childbirth, dental or surgical analgesia, and phantom limb pain.</td>
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5. The Nature of Hypnosis and Memory: Principles and Techniques of Age Regression and the Working Through of Trauma

**Recommended Learning Objectives:**
A. Highlight current literature on hypnosis and memory, and its implications for clinical work.
B. Identify 3 different techniques for facilitating age regression.
C. Identify at least 5 contraindications for conducting age regression and abreactive work.
D. Discuss how to facilitate therapeutic abreaction and methods for modulating affective intensity in age regression.
E. Highlight current literature on trauma and its impact upon personality development and functioning.
F. Identify hypnotic processes which facilitate ego stability and/or orientation to self during trauma work.
G. Identify several methods for the cognitive reframing and working through of trauma.

**Recommended Content:** It is advised that memory be defined as imperfect, in or out of hypnosis, citing research summarized by Loftus. Much is still not known and significant deficiencies exist in hypnosis and memory research. But memories retrieved through hypnosis, like memory in general, may consist of accurate information, confabulation, and inaccurate memories. Recall can improve under some conditions, and the use of hypnotic techniques may or may not contribute to that enhancement. Since hypnosis is widely regarded by many people to be a controlled dissociation and because of the evidence that many trauma and abuse victims enter trance-like, dissociative states during and after trauma, recreating an emotional and dissociative context through hypnosis integrated within psychotherapy may facilitate both the recovery and working through of traumatic memories. Traumatic memory may be encoded differently than normal memory. Abundant evidence suggests that traumatically induced amnesia exists. Increasing evidence supports the existence of delayed memory or so-called robust repression. But, if not used cautiously, hypnotic procedures can increase false confidence, likely from suggestion effects that create expectations that there will be accurate recall. Thus, pre-hypnotic and hypnotic suggestions must create a neutral atmosphere concerning whether or not further information or accurate information will be revealed. Because persons may be led to change perceptions or create pseudomemories through questioning either in or out of hypnosis, clinicians must always work cautiously and avoid leading patients. High hypnotizable subjects, whether or not hypnosis is used, appear more prone to developing pseudomemories. But it also appears that subjects may often be capable of distinguishing preexisting memories from pseudomemories. Currently there is no litmus test that allows anyone to know whether a memory is relatively accurate, confabulated, or distorted in the absence of corroborating evidence. Patients must therefore be cautioned that if they consider confronting alleged perpetrators of abuse, their unsubstantiated memories, no matter how vivid or emotional, may lack sufficient weight in a court of law. We advise that students receive a copy of the 1994 ASCH guidelines for clinicians in working with hypnosis and memory in cases involving possible abuse and we recommend that forensic guidelines for the conduct of hypnotic interviews be presented. Methods of facilitating age regression should be reviewed (e.g., verbalizations, and specialized techniques such as the use of a time machine, or the affect bridge), along with the fact that positively-focused age regression may be used in treatment. Indications and contra indications (e.g., thought disorder, inadequate ego-strength, medically impaired patients where an abreaction may pose a risk to health, without permission of the patient, when there is not adequate time) for age regression and abreaction should be reviewed. The importance of using free-recall following initial suggestions for age regression, without asking leading questions about content, should be stressed. We encourage that time be allotted to explain how to facilitate therapeutic abreaction and for reviewing available methods for modulating and containing affective intensity in age regressions. Techniques for cognitive reframing and the working through of trauma (e.g., positive and negative reframing, altering cognitive overgeneralizations, reframing through metaphors, obtaining unconscious commitments) may also be reviewed or illustrated. The importance of consciously integrating material that is uncovered should be emphasized. The two and a half hours allocated for this topic is a minimum time requirement, and more time will presumably be necessary to promote thorough mastery of this complex topic.

6. Hypnosis in the Treatment of Anxiety and Phobic Disorders

**Recommended Learning Objectives:**
A. Review principles stemming from research data on the treatment of anxiety and phobic disorders.
B. Explicate a minimum of 3 hypnotic techniques for treating these disorders, and be able to provide a rationale for using each method.

**Recommended Content:** Fundamental principles for treating these disorders should be reviewed from the non-hypnotic literature prior to
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<tr>
<th>Required Topic Areas</th>
<th>Minimum Time Recommended (Mins.)</th>
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<tr>
<td>7. Hypnotic Treatment of Habit Disorders</td>
<td>90</td>
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**Recommended Learning Objectives:**
A. Discuss research literature on hypnosis in the treatment of smoking and obesity.
B. Identify at least 4 different types of suggestions or hypnotic techniques that may be used in the treatment of smoking or obesity.
C. Review how hypnosis may also be used to work with other habit disorders such as nail biting and trichotillomania.

**Recommended Content:** After reviewing research, we urge the elaboration and/or demonstration of specific hypnotic treatment techniques and suggestions, such as: ego-strengthening suggestions, utilizing patient motivations as part of suggestions, trance ratification procedures for increasing self-efficacy, reframing suggestions (e.g., to respect and protect the body), suggestions to undermine rationalizations and increase impulse control, suggestions targeting irrational cognitions and to promote positive self-talk, mental rehearsal and success imagery, pseudo-orientation in time into the future, symbolic imagery techniques, self-hypnosis training, suggestions aimed at relapse prevention and coping with specific problematic situations, suggestions to enhance motivation, use of unconscious commitments, suggestions for managing cravings, aversion suggestions, and suggestions utilizing various hypnotic phenomena therapeutically (e.g., time distortion, negative hallucination, amnesia).

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<th>Required Topic Areas</th>
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<tr>
<td>8. Constructing Therapeutic Metaphors and Indirect Suggestions</td>
<td>60</td>
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**Recommended Learning Objectives:**
A. Introduce ideas about how to construct therapeutic metaphors as a type of hypnotic suggestion.
B. Provide at least 2 examples of metaphors that might be used with clinical problems.

**Recommended Content:** We advise providing examples of therapeutic metaphors that may be used with a variety of clinical problems, along with discussing principles in constructing metaphors.

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<th>Required Topic Areas</th>
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<tr>
<td>9. Insight-Oriented and Exploratory Hypnotic Techniques</td>
<td>90</td>
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**Recommended Learning Objectives:**
A. Discuss indications and contraindications for using an insight-oriented hypnotic approach.
B. Be capable of describing at least 3 exploratory hypnotic methods.

**Recommended Content:** It is recommended that students be exposed to possible indications for using insight-oriented, hypnoanalytic techniques. For example, exploratory methods may be indicated with: long-standing and complex problems manifested through multiple symptoms; where there appears a strong likelihood that the problem is associated with dynamic functions, purposes, historical factors, and inner conflicts; with psychologically-minded patients who expect and prefer an insight-oriented approach to treatment; when patients possess the impulse control and resources to tolerate an insight-oriented approach to therapy; when suggestive hypnotic sessions with hypnotherapy responsive individuals have not yielded expected benefits and/or resistance is encountered; at a pattern search and contemplative stage of treatment. In contrast, such methods may be initially contraindicated with: situational, monosymptomatic, and habit disorders; over-intellectualizing patients who already possess insight and need to translate insight into action; with less intelligent or psychologically-minded persons who do not have the preference, impulse control or resources to tolerate a more insight-oriented approach. With these types of problems and situations, if two to four sessions of suggestive hypnosis do not yield positive results, a more insight-oriented approach might then be used. Students should appreciate that at times hypnoanalytic methods may accelerate the insight-oriented stage of treatment. It is further advised that students be introduced to specific techniques such as: ideomotor signaling, guided imagery, hypnotic free association, automatic writing, the unconscious self-image technique, hypnotically induced dreams, and hypnotherapy ego-state therapy. Other hypnoprotective techniques may include the theater technique, cloud projection, visualized automatic writing, and hypnotic drawing.

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<tr>
<th>Required Topic Areas</th>
<th>Minimum Time Recommended (Mins.)</th>
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<tr>
<td>10. Ethics and Professional Conduct</td>
<td>30</td>
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**Recommended Learning Objectives:**
A. Describe ethical-legal issues and standards for professional conduct in using hypnosis clinically.
B. Introduce certification requirements in clinical hypnosis, and the
Required Topic Areas | Minimum Time Recommended (Mins.)
---|---
desirability of and requirements for advanced certification through taking diplomate board examinations.
C. Identify professional conduct and legal issues relevant to clinical hypnosis.

Recommended Content: We encourage discussion of ethical guidelines, the value of obtaining informed consent, adhering to guidelines and cautions in using hypnosis with exploration of memories, and in only using hypnosis to treat conditions that one is qualified to treat with non-hypnotic methods. Hypnosis should also not be used by professionals for entertainment purposes. Therapists should also be cautious because the imbalance of power created in a hypnotic encounter can tempt some therapists to cross prohibited boundaries. Students should be introduced to the major hypnosis societies, and urged to pursue advanced certification after five years in the field by taking diplomate board examinations.

11. Integrating Hypnosis into Clinical Practice 300-360

In order to allow the flexibility to modify the curriculum to meet the needs and interests of both instructors and students, the remaining five hours in a 20 hour model curriculum should be tailored by including at least two of the following topics. The instructor should specify learning objectives for each topic.

**Intermediate/Advanced Topics:**
A. Hypnotic Inductions and Utilizing Hypnosis with Children.
B. Practicum in Formulating Direct and Indirect Hypnotic Suggestions.
C. Case Consultation in Integrating Hypnosis into Clinical Practice (in Psychotherapy, Medicine and Nursing, or Dentistry).
D. Demonstrations of the Administration of Hypnotic Susceptibility Scales.
E. Practice in Administering Scales of Hypnotic Responsiveness.
F. Ericksonian Hypnotherapy.
G. Hypnosis in Behavioral Medicine and with Psychosomatic Disorders.
H. Hypnoanalysis.
I. Integrating Hypnosis and Psychotherapy.
J. Hypnosis in the Treatment of Dissociative Disorders.
K. Hypnosis in the Treatment of Severely Disturbed Patients.
L. Hypnotic Ego-State Therapy.
M. Hypnosis in Sex Therapy.
N. Hypnosis in Marital and Family Therapy.
O. Hypnotic Preparation for Surgery, Childbirth, and Hypnoanesthesia.
P. Hypnosis with Burns and Emergencies.
American Society of Clinical Hypnosis  

REQUIREMENTS FOR  
CERTIFICATION IN CLINICAL HYPNOSIS  

I. Qualifications  
The applicant must meet the following qualifications: An MD, DDS, DMD, DO, DPM, DC, PhD, PsyD, or an equivalent doctoral degree with psychology or speech-language pathology as the major field of study, or a masters degree in nursing, social work, psychology, marriage and family therapy, mental health counseling or in speech-language pathology from an accredited college or university; and membership in a professional society other than ASCH or SCEH consistent with his/her degree.  

II. Licensure  
A. The Applicant shall hold a current valid state/provincial regulatory license for independent practice in one of the following disciplines: Medicine, Psychology, Dentistry, Podiatry, Nursing, Social Work, Mental Health Counseling or Marriage and Family Therapy.  
B. If such a regulatory system is not in effect in the state/province where the applicant practices, one of the following criteria shall be met:  
1. Listing in the National Register of Health Service Providers in Psychology.  
2. Certification by the Academy of Certified Social Workers or the National Board of Examiners in Clinical Social Work.  
3. Certification by the American Nurses Association or other equivalent national certifying body.  
4. Full Membership in the American Association for Marriage and Family Therapy.  
5. Certification by the National Board of Certified Counselors.  

III. Clinical Hypnosis Workshop Training:  
The applicant shall have completed a minimum of:  
A. Forty hours of post-degree, ASCH approved education. This training shall consist of 20 hours of beginning training and 20 hours of intermediate training. Up to 20 hours of “Ericksonian Hypnosis” may be be accepted towards the 40 hour requirement as long as the training adheres to the standards of training referred to below.  
B. The applicant shall also have completed 20 hours of individualized training with an ASCH Approved Consultant. This individualized training may occur in one-to-one training or in a small group of one Approved Consultant to not more than six trainees. Twenty cumulative hours of individualized consultation can be credited one hour to one hour of one to one consultation. Individualized objectives should be specified for each person including individualized learning experience.  

All training must fit the guidelines published in the manual Standards of Training (ASCH Press, 1994). It is the responsibility of the applicant to provide with his or her application sufficient documentation to demonstrate that his or her training is compatible with these standards. Any applicant submitting non-ASCH training must document their attendance and number of contact hours. All workshop training must be approved by the Certification Committee for acceptance as comparable training.  

IV. Clinical Practice  
The applicant must document two years of independent practice using hypnosis in their clinical practice, and describe that use of clinical hypnosis in their practice.  

V. Documentation  
The following documentation shall be for review by the ASCH Certification Committee and will become the property of ASCH.  
A. Completed application for ASCH Certification in Clinical Hypnosis along with the proper, non-refundable application fee ($150 members; $350 non-members).  
B. Official transcript of program in which the highest degree was earned (not required for ASCH or SCEH members).  
C. A copy of current valid license or certification in one of the approved disciplines as outlined in Section II A.  
D. Official transcripts, attendance certificates, curriculum or program transcripts as requested by the Certification Committee. Documentation of attendance and actual contact/CEU hours is required for all non-ASCH training.  
E. At least 20 hours of individualized training with an ASCH Approved Consultant as follows:  
1. ASCH Consultation and Learning Contract Verification Form signed by the applicant and ASCH Approved Consultant. If the required individualized training was conducted with more than one Approved Consultant, a separate Verification Form is required for each Approved Consultant. (Learning Contract should be obtained from Approved Consultant).  

VI. Letters of Recommendation  
Two letters of endorsement from professional colleagues who can comment on the applicant’s professional ethics, use of hypnosis, and character. These letters are intended to comment on overall clinical demeanor, not competence. (Not required for applicants who have been members of ASCH for 5 or more years).
VII. Miscellaneous
A. All applicants for Certification shall be required to comply with and sign a statement of agreement to comply with the ethical standards established by the American Society of Clinical Hypnosis as expressed in the ASCH Code of Conduct.

B. Upon approval by the Certification Committee, the successful applicant shall receive a certificate in recognition of having met the ASCH requirements for Certification in the area of clinical hypnosis. This certificate shall be subject to renewal every three years.

C. If you are applying for Approved Consultant status (which requires completion of a different application), Certification is automatic and you do not need to complete this application.

D. ASCH Certification shall be noted in the on-line ASCH Membership and Referral Directories.

E. Violation of ethical standards or loss of qualifications may result in revocation of ASCH Certification.

F. All protests and appeals are subject to review by the ASCH Executive Committee.

VIII. Case Consultation Learning Contract
The requirements for ASCH Certification in Clinical Hypnosis includes 20 hours of individualized training and case consultation with an ASCH Approved Consultant in Clinical Hypnosis. A list of ASCH Approved Consultants may be obtained from the ASCH Central Office. Prior to beginning the 20 hours of individualized instruction, it is recommended that a "learning contract" be completed by the consultant and the student. The learning contract should be individualized and tailored to the unique learning needs of the student. The training with a consultant must be individualized to qualify as ASCH approved training. The individualized training is not and should not be represented as clinical supervision. It should also be noted that dual relationships are unethical and individualized training may not be provided to individuals in the context of psychotherapy or other professional relationships that provide clinical services. The learning contract should be used to specify the learning needs, learning objectives, learning resources and strategies, and methods for evaluating achievement of learning goals. Completion of the individualized training must be documented on a form titled “ASCH Consultation and Learning Contract Verification” form. (The learning contract can be obtained from the Approved Consultant.) For more information, contact the ASCH Central Office, 140 N. Bloomingdale Road, Bloomingdale, IL 60108, USA. Phone: 630-980-4740 Fax: 630-351-8490

American Society of Clinical Hypnosis
REQUIREMENTS FOR APPROVED CONSULTANT IN CLINICAL HYPNOSIS

I. Qualifications
The applicant must meet the following qualifications: An MD, DDS, DMD, DO, DPM, DC, PhD, PsyD, or an equivalent doctoral degree with psychology as the major field of study, or a masters degree in nursing, social work, psychology, marriage and family therapy, or mental health counseling from an accredited college or university; and membership in a professional society other than ASCH or SCEH consistent with his/her degree.

II. Licensure
A. The Applicant shall hold a current valid state/provincial regulatory license for independent practice in one of the following disciplines: Medicine, Psychology, Dentistry, Podiatry, Chiropractic, Nursing, Social Work, Speech Language Pathology, Mental Health Counseling or Marriage and Family Therapy.

B. If such a regulatory system is not in effect in the state/province where the applicant practices, one of the following criteria shall be met:

1. Listing in the National Register of Health Service Providers in Psychology.

2. Certification by the Academy of Certified Social Workers or the National Board of Examiners in Clinical Social Work.

3. Certification by the American Nurses Association or other equivalent national certifying body.

4. Full Membership in the American Association for Marriage and Family Therapy.

5. Certification by the National Board of Certified Counselors.

III. Clinical Hypnosis Workshop Training:
A. The applicant shall have completed a minimum of one hundred hours of post-degree, ASCH approved education. Up to fifty hours of “Ericksonian Hypnosis” may be accepted towards the one hundred hour requirement as long as the training adheres to the standards of training referred to below.

B. The applicant shall also have completed 20 hours of individualized training with an ASCH Approved Consultant. This individualized training may occur in one-to-one training or in a small group of one Approved Consultant to not more than six trainees. Twenty cumulative hours of individualized consultation can be credited one hour to one hour of one-to-one consultation. Individualized objectives should be specified for each person including individualized learning experience. All training must fit the
IV. **Clinical Practice**
The applicant must document five years of independent practice within their use of hypnosis in clinical practice, and describe their use of clinical hypnosis in their practice.

V. **Advanced Membership**
The applicant must meet one of the following criteria:

A. The applicant shall hold Diplomate status in the American Board of Psychological Hypnosis, the American Board of Medical Hypnosis, the American Board of Hypnosis in Dentistry, or the American Hypnosis Board for Clinical Social Work; or,

B. The applicant shall hold Fellowship status in the American Society of Clinical Hypnosis or the Society for Clinical and Experimental Hypnosis; or,

C. The applicant shall document a minimum of five years of membership in ASCH or SCEH; or,

D. Otherwise eligible applicants who have not been eligible for ASCH or SCEH membership during the past may submit evidence of equivalent membership (Component Section membership, etc.), and evidence of extensive training for consideration by the Certification Committee.

VI. **Documentation**
The following documentation shall be submitted in duplicate for review by the ASCH Certification Committee and will become the property of ASCH.

A. Completed application for ASCH Certification as an Approved Consultant in Clinical Hypnosis along with the proper, non-refundable application fee ($150 members; $350 non-members). Those applying for elevation from regular certification to approved consultant need only complete those sections that would entitle them to be elevated and enclose the proper, refundable application fee ($100 members, $300 non-members).

B. Official transcript of program in which the highest degree was earned (not required for ASCH or SCEH members).

C. A copy of current valid license or certification in one of the approved disciplines.

D. Official transcripts, attendance certificates, curriculum or program transcripts as requested by the Certification Committee documenting at least 100 hours of ASCH approved workshop training. Documentation of attendance and actual contact/CEU hours is required for all non-ASCH training.

E. At least 20 hours of individualized training with an ASCH Approved Consultant including a completed ASCH Consultation and Learning Contract Verification Form signed by the applicant and ASCH Approved Consultant. If the required individualized training was conducted with more than one Approved Consultant, a separate Verification Form is required for each Approved Consultant. (Learning Contract should be obtained from an ASCH Approved Consultant). If the Approved Consultant wishes to discuss the requirements specified in this application, please request that he or she contact the ASCH Central Office at 140 N. Bloomingdale Rd., Bloomingdale, IL 60108, USA; Telephone: 630-980-4740; FAX: 630-351-8490.

F. Applicants must complete the requirement for training on becoming an Approved Consultant. This training can be completed on a one-to-one basis with an Approved Consultant or by attending a workshop on becoming an Approved Consultant. If the Approved Consultant with whom the applicant desires to work wishes to discuss the requirements, he or she should call the ASCH Central Office at 630-980-4740.

VII. **Letters of Recommendation**
One letter of endorsement from professional colleagues who can comment on the applicant’s professional ethics, use of hypnosis, and character should accompany the application. These letters are intended to comment on overall clinical demeanor, not competence. (Not required for applicants who are members of ASCH).

VIII. **Miscellaneous**

A. All applicants for Approved Consultant shall be required to comply with and sign a statement of agreement to comply with the ethical standards established by the American Society of Clinical Hypnosis as expressed in the ASCH Code of Conduct.

B. Upon approval by the Certification Committee, the successful applicant shall receive a certificate in recognition of having met the ASCH requirements for Certification and Approved Consultant in the area of clinical hypnosis. This certificate shall be subject to renewal every three years.

C. If you are applying for Approved Consultant status, certification is automatic and you do not need to complete the application for Certification in Clinical Hypnosis.

D. ASCH Certification as an Approved Consultant shall be noted in the online ASCH Membership and Referral Directories.
E. Violation of ethical standards or loss of qualifications may result in revocation of ASCH Certification as an Approved Consultant.

IX. Case Consultation Learning Contract

The requirements for ASCH Certification as an Approved Consultant in Clinical Hypnosis include 20 hours of individualized training and case consultation with an ASCH Approved Consultant in Clinical Hypnosis. A list of ASCH Approved Consultants may be obtained from the ASCH Central Office. Prior to beginning the 20 hours of individualized instruction, it is recommended that the consultant and the student complete a “learning contract.” The learning contract should be individualized and tailored to the unique learning needs of the student. The training with a consultant must be individualized to qualify as ASCH approved training. The individualized training is not and should not be represented as clinical supervision. It should also be noted that dual relationships are unethical and individualized training may not be provided to individuals in the context of psychotherapy or other professional relationships that provide clinical services. The learning contract should be used to specify the learning needs, learning objectives, learning resources and strategies, and methods for evaluating achievement of learning goals. Completion of the individualized training must be documented on the “ASCH Consultation and Learning Contract Verification” form. (The learning contract can be obtained from the Approved Consultant.) For more information, contact the ASCH Central Office.

ASCH RENEWAL OF CERTIFICATION GUIDELINES

I. Designation of certification and/or approved consultant status shall be for a period of three years.

II. The applicant for renewal must document a current and valid state/provincial license for independent practice in the state/province where they practice. Applicants for renewal shall not have been found guilty of violations of the ASCH Code of Conduct.

III. Applicants for renewal shall have completed a minimum of twenty (20) hours of acceptable continuing education work in the past three years.

IV. Applicants for renewal shall submit documentation as requested and pay a non-refundable processing fee as determined by the Executive Committee. Renewal requirements are subject to change from time to time as approved by the Executive Committee.

V. The current fee for application for renewal is $65.00 for members and $125.00 for non-members.

ADVANCED CERTIFICATION:
DIPLOMATE BOARDS IN CLINICAL HYPNOSIS

THE AMERICAN BOARD OF PSYCHOLOGICAL HYPNOSIS

ABPH certifies psychologists in the areas of clinical and experimental hypnosis. Applicants must have a doctoral degree, membership or eligibility for membership in American Psychological Association, and a minimum of 5 years of acceptable experience with hypnosis, including supervised experience. Individuals seeking the diplomate in clinical hypnosis must also be licensed or certified, and possess or be eligible for the American Board of Professional Psychology diplomate in clinical or counseling psychology. Persons seeking the diplomate in experimental hypnosis must have 5 years of acceptable experience with research in hypnosis, significant research publications in the field, and sufficient knowledge of clinical principles to work safely with hypnosis. Applicants are required to have 3 reference letters, to submit a work sample consisting of a brief history and a transcript of one or more therapy hours in which hypnosis played a significant role, and submit reprints of all relevant professional publications (for experimental boards). Oral examinations are then administered by 3 examiners during annual meetings of ASCH, APA, or SCEH. This examination covers topics which include the work sample submitted, clinical applications of hypnosis, theories and conceptual issues pertaining to hypnosis, ethics, and (for experimental examinees) issues and problems of research design and methodology in hypnosis research. A workshop on preparing for diplomate board examinations is usually presented at the annual meetings of the American Society of Clinical Hypnosis. Further information about applications and the current address of the Board Secretary may be obtained through the ASCH National Office.

THE AMERICAN BOARD OF MEDICAL HYPNOSIS

ABMH is the only approved organization certifying advanced competency of physicians in medical hypnosis. ABMH makes available mentors on request to interested candidates applying for board certification. Applicants must pass a 2 hour written certifying examination, a 2 hour oral examination, and must be a licensed physician in good standing and hold active Board Certification in his/her specialty. A minimum of 2 years of clinical hypnosis experience is required for admission to the examination. Candidates must also submit an audio or videotape recording representative of their clinical hypnosis work with patients. Examinations are offered twice yearly at the annual meetings of ASCH and SCEH. A workshop on preparing for diplomate board examinations is usually presented at the annual meetings of the American Society of Clinical Hypnosis. Further information about applications and the current address of the Board Secretary may be obtained from the ASCH National Office.
THE AMERICAN BOARD OF HYPNOSIS IN DENTISTRY

ABHD certifies advanced competency of dentists in dental hypnosis. Before being admitted for the examination, the applicant must have 5 years of experience and training in using hypnosis or in research in hypnosis. In addition to documentation of training, the applicant must write a 2500 word essay on hypnosis and dentistry, submit 2 case histories, and provide reprints of any published articles on hypnosis. Written and oral examinations focus on theories of hypnosis, psychological understanding of the phenomena encountered (including abstractions that can occur during dental applications), demonstration of direct and indirect inductions, and ability to recognize a trance-like state. A workshop on preparing for diplomate board examinations is usually presented at the annual meetings of the American Society of Clinical Hypnosis. Further information about applications and the current address of the Board Secretary may be obtained from the ASCH National Office.

THE AMERICAN HYPNOSIS BOARD FOR CLINICAL SOCIAL WORK

AHCSW offers a Diplomate in Clinical Hypnosis to qualified Clinical Social Workers. Applicants must have a masters or doctoral degree in social work, a Diplomate of the National Association of Social Workers, the American Board of Examiners in Clinical Social Work, or be eligible for either examination, and a minimum of 5 years of acceptable experience with hypnosis, including supervised experience. Individuals seeking the diplomate in clinical hypnosis must also be licensed or certified: Applicants are required to have 3 reference letters, to submit a work sample consisting of a brief history and a transcript of one or more therapy hours in which hypnosis played a significant role, and submit reprints of all relevant professional publications. Oral examinations are then administered by 3 examiners during annual meetings. This examination covers topics which include the work sample submitted, clinical applications of hypnosis, theories and conceptual issues pertaining to hypnosis, and ethics. A workshop on preparing for diplomate board examinations is usually presented at the annual meetings of the American Society of Clinical Hypnosis. Further information about applications and the current address of the Board Secretary may be obtained through the ASCH National Office.

RECOMMENDED READING LIST

History of Hypnosis

Theories of Hypnosis

Clinical Hypnosis Textbooks


Textbooks Emphasizing Experimental Hypnosis and Research


Specialty Books on Hypnosis in Medicine, Dentistry, and Nursing


Torem, M. S. (1992). Hypnosis and its Clinical Applications in Psychiatry and Medicine, Volumes 1 & 2. Volumes of Psychiatric Medicine, 10(1,4).


Hypnosis and Children


Forensic Hypnosis, Memory, and Risks of Hypnosis


American Society of Clinical Hypnosis (ASCH)
CODE OF CONDUCT

Introduction
The ASCH Code of Conduct is comprised of two sections, Ethical Principles and Ethical Standards. The Ethical Principles serve as philosophical guidelines that help to structure a member’s practice of hypnosis. The Ethical Standards serve as practical or applied guidelines for the members’ practice.

Acceptance of membership in, or Certification by, ASCH commits the member or certified clinician to the Code of Conduct. For the purposes of this document, both ASCH members and those non-members certified by ASCH will be referred to as “members.”

In subscribing to this Code, members are required to cooperate in its implementation and abide by any disciplinary rulings based upon this Code. Members should take adequate measures to discourage, prevent, expose, and correct unethical conduct of colleagues. Additionally, members should be equally available to defend and assist colleagues unjustly charged with unethical conduct.

The Code should not be used as an instrument to deprive any member of the opportunity or freedom to practice with complete professional integrity; nor should any disciplinary action be taken on the basis of this Code without maximum provision for safeguarding the rights of the member(s) affected.

Ethical Principles
I. Competence: Members strive to attain the highest levels of professional competence.

A. Members use hypnosis only within the bounds of their training and expertise; within their primary discipline; and within the context of a professional relationship;

1. A “professional relationship” is defined by the member’s primary discipline and includes consultation or supervision of colleagues.

B. Members’ expertise is determined, in part, by their professional education, training, licensure, and experience;

C. Members recognize, and are respectful of, any limitations to their expertise;

D. Members strive to maintain current knowledge of research, issues, and methods in hypnosis;

II. Professional Responsibility: Members serve the best interests of their clients or patients.

A. Members accept responsibility for the care of their clients or patients consistent with their discipline and licensure;
B Members seek out consultation and/or supervision when in doubt regarding their clinical practices or when questioned by others about their clinical practice;
C. Members participate and cooperate with inquiries regarding their practices;
D. Members accept responsibility for, and when necessary the consequences of, their behavior;
E. Members accept responsibility to monitor and make appropriate changes in their practice to comply with the Ethical Principles or Ethical Standards of this Code;
F. Members seek to educate the public about the proper and scientific use of hypnosis.

Ethical Standards
I. ASCH members uphold the professional standards, ethics, and codes of conduct of their primary discipline.
II. ASCH members remain in good standing in the association or society that oversees the member’s primary discipline.
III. ASCH members maintain a license to practice at the independent, unrestricted, or unsupervised level.
IV. ASCH members do not support the practice of hypnosis by laypersons.
   A. The “practice of hypnosis” means the provision of services, or the offer to provide services, utilizing hypnosis to individuals or groups regardless if a fee or honorarium is charged, offered or paid.
   B. A “layperson” is:
      1. an individual lacking professional education and clinical training in a health care discipline, including but not limited to those recognized by ASCH for membership and/or certification, or
      2. an individual not pursuing a degree, from a regionally accredited institution, in a health care discipline including but limited to those recognized by ASCH for membership and/or certification.
   C. Members do not provide hypnosis training to laypersons.
V. Public and Media Presentation:
   A. ASCH members do not use hypnosis for entertainment purposes.
   B. When members do appear in public forums, such as on television or some other audio or video format, they take care to ensure that any demonstration of hypnosis is done in such a way as to prevent or minimize risk to unknown audience participants.
      1. For example, when a videotape demonstration is shown on television, the member takes steps to ensure that the complete audio portion of the induction and deepening phases are muted.
   C. ASCH members ensure when they present hypnosis, in any format, to the public the member does so within the spirit of this Code and within the guidelines of their primary discipline.
D. Members honestly and fairly represent their professional competency, qualifications and capabilities to the public and media, and refrain from making false, misleading, deceptive or unsubstantiated statements in resumes, advertising and other means of soliciting clients or patients.
VI. Nothing in this Code shall prohibit members from:
       Teaching hypnosis to individuals or groups who, upon completion of such training, would be eligible for ASCH membership,
       Teaching students of health care disciplines, including but not limited to those recognized by ASCH for membership and/or certification,
       Teaching patients or clients the use of self-hypnosis for that individual’s own therapeutic use, or
       Teaching about hypnosis in any forum that serves to properly educate and inform the consumer or professional public about hypnosis.
VII. When ASCH members engage in human subjects research, they do so within the accepted standards of their primary discipline, taking precautions not to cause emotional or physical harm to their subjects.
VIII. When this Code is unclear on an issue, question, or complaint and when deemed appropriate by the ASCH Executive Committee, guidance is sought from the ethical standards of the member’s primary discipline professional association and/or the member’s licensing board.

Enforcement
1. Any person, whether or not a member of ASCH, may initiate a charge of ethical violation against a member of ASCH.
2. Any charge must be submitted in writing to the Ethics Committee, must specify the time and place of the violation, and must be signed by the complainant.
3. The Ethics Committee shall inform the member in writing of the charges against the member and solicit the member’s response to the charges.
4. If, upon receiving the response of the member, the Ethics Committee determines that cause for further inquiry exists, the Ethics Committee shall set a time and place for a hearing and shall notify the member and the complainant, by certified mail, of the time and place.
5. The purpose of the Ethics Committee hearing is to gather all the facts related to the alleged violation. The charged member shall have the privilege of appearing in person, or may submit a written defense to the Ethics Committee at least twenty-four hours prior to the time of the hearing. At the hearing, the charged member shall have the right to cross examine the complainant and any witnesses who may appear against the member. The charged member shall also have the right to present witnesses. The
complainant shall be able to direct questions to the charged member only through a committee member. The hearing may be recorded and a transcript of the proceedings, if any, shall be available at cost.

6. No later than thirty days following the hearing, the Ethics Committee shall submit a report of its findings to the Executive Committee and recommend either:
   a. dismissal of the charges,
   b. censure or warning,
   c. suspension, or
   d. expulsion.

The Ethics Committee shall send by certified mail a copy of its report and recommendation to the charged member.

7. If the Ethics Committee finds the member guilty of any of the charges or recommends censure, warning, suspension or expulsion, the member shall have thirty days from the receipt of the Ethics Committee report to submit to the Executive Committee written objections to the findings or recommendations of the Ethics Committee.

8. The Executive Committee shall review the findings and recommendation of the Ethics Committee and any written objections submitted by the member and shall reach a final decision. In accordance with the By-Laws, the Executive Committee shall not expel a member without holding a hearing at which the accused may appear and be represented by counsel. The Executive Committee shall also have the right to be represented by counsel at such a hearing. The Executive Committee shall notify the member in writing, by certified mail, of its decision.

   In accordance with the By-Laws, a decision of censure or warning will be a matter of Executive Committee record only. A decision of suspension or expulsion will be reported to the Board of Governors and to the membership of ASCH through the “Corrections to the Directory” section of the Newsletter.

   Approved 4/6/2003