American Society of Clinical Hypnosis

Ethics for Telemedicine and Distance Education

Ethics Committee Charge

In the current Covid-19 era, the ability of ASCH to offer in-person professional training opportunities has been postponed indefinitely. Whether professional training in the post-Covid-19 era will return to its previous baseline remains to be determined. In the meantime, utilization of online resources for the delivery of certain healthcare services and access to online learning is increasing due to technological advances and also borne of necessity by the demands imposed by the current pandemic. Therefore, the ASCH Ethics Committee was asked to:

- provide a statement of ethical considerations regarding the utilization of clinical hypnosis with clients via telehealth or phone by clinicians trained in clinical hypnosis, and
- provide a statement of ethical considerations in offering training in clinical hypnosis to existing ASCH members and to qualified healthcare clinicians seeking to learn clinical hypnosis through ASCH-ERF training programs.

The Ethics Committee generated a set of questions that we felt would shape our response to the charge we were given. They included:

- ASCH workshop Levels 1 and 2 emphasize a specific type of 'clinical hypnosis' training that includes indicators that 'trance' is present. Given limitations of telemedia for direct observation of operators and subjects with sufficient detail and clarity, should a more conversational form of hypnotic induction/trace evocation be considered?
- What considerations and procedures should be taken when re-alerting / re-orienting and in the case of abreactions?
- What criteria should clinicians consider in "knowing" their online clients/patients (assuming no face-to-face contact has yet occurred) before any form of clinical hypnosis is introduced?
- What types of liability release forms or informed consent documents pertaining to clinical hypnosis should be obtained by clinicians prior to introducing hypnosis in either educational or treatment settings?
- What type of telehealth training for potential ASCH workshop faculty and/or clinicians in treatment settings should be required, if any?
- Were a more conversational form of hypnosis to be emphasized, would this circumvent the need for informed consent (i.e., what would a person be consenting to?), or how would it impact the structure of such documentation?
- Is this pandemic pushing not only the bounds of the physical context in which clinically integrated hypnosis and clinical hypnosis training occurs but the need for consideration of modification of what it is that ASCH teaches with regard to "clinical hypnosis"?

This Ethics Committee document, arising in response to this Committee's charge, should remain a living document that continues to evolve, even though the specific pandemic-related issues that prompted this work gradually resolve. We recognize that clinical training and practice activities, and the settings in which they are held, will, in all likelihood, continue to evolve. Therefore, attention must continue to be paid by ASCH to maintain the highest quality training, consistent with professional, ethical standards, regardless of the emerging mediums through which professional education and training may be conducted.

This document was created as a "guideline" for ASCH members (APA, 2013). As such, it is distinct from a "standard," which is often mandatory and to which legal enforcement actions are usually affixed. Instead, this guideline's intent is to inform clinicians about how to apply their current standards of training as they relate to the emerging world of delivering their services through telehealth means. The guideline is aspirational. The Ethics Committee sought to inform ASCH members about specific issues that arise when considering telehealth services delivery, to support the "continued systematic development" of our professions, and to enable us to continue to maintain high levels of professional practice (APA, 2013).

This document does not replace nor assume professional authority over laws and regulations that currently govern professional practice behavior. Clinicians must assume responsibility for being familiar with the specific professional practice standards relevant to their professional role, practice jurisdiction, and practice settings.

Current definitions of telehealth services cast a wide net. Interactive video teleconferencing, telephone calls, emails, chats, texts, access to blogs/vlogs, social media, posted psychoeducational material, online training, and more can be considered telehealth services. Therefore, clinicians must familiarize themselves with the potential benefits and limitations, including ethical issues (e.g., privacy/confidentiality or personal data security concerns) that are associated with the use of these various telehealth resources.

This guideline recognizes that telehealth technologies offer a unique opportunity to deliver healthcare services to individuals or populations that have been less well served through face-to-face services. Telehealth also has the potential to expand the range of services that are available to any given individual or population. However, these opportunities carry increased risks for both clinicians and clients, which this document seeks to identify. Broadly speaking, clinicians choosing to utilize telehealth services must seek to deepen their knowledge of and competence with the delivery of telehealth services. In addition, clinicians much be able to convey to clients a full understanding of the risks pertaining to privacy and data security when engaging in telehealth, and to obtain appropriate consent to proceed accordingly.

Primary Considerations

- The pandemic has disrupted the ability of clinicians to deliver clinical services incorporating clinical hypnosis directly to clients and patients via face-to-face interactions, except perhaps in acute care hospital settings.

- That pandemic has disrupted the ability of ASCH/ASCH-ERF to convene in-person professional training in clinical hypnosis.
- The primary source of societal revenue for ASCH has involved in-person training of qualified health professionals. Thus, the survival of ASCH in this period of physical distancing is threatened by the loss of revenue the pandemic has caused.
- The pandemic offers a unique opportunity, prompted by this crisis, to examine the strengths and limitations of utilizing clinical hypnosis in online interactions between clinicians trained by ASCH and their clients/patients, as well as for use of online resources as a means of delivering high quality educational training in clinical hypnosis to individuals seeking to learn clinical hypnosis (i.e., Level I and Level II training) up to and including advanced-level training to clinicians already trained in clinical hypnosis.

Suggested General Guidelines

Clinical hypnosis is fundamentally a relationship-based process that relies upon empathic attunement to verbal and especially non-verbal statements and cues exchanged between the clinician and client/patient to elicit or evoke states of trance that enable the client/patient's change capacities to emerge. Attention to the clinician's own internal responses activated by the interaction with the client/patient represents an additional source of useful clinical information that may be attenuated when engaged in telehealth interactions (Bromberg, 2014). As such, any impediments to a direct, face-to-face connection between clinician and client/patient has the potential to degrade or erode the positive benefits afforded by incorporation of clinical hypnosis into treatment activities. Moreover, the absence of a direct, face-to-face connection between the clinician and the client/patient increases the risks that the client/patient could experience unintended and unobserved adverse reactions that could more easily and immediately be recognized and addressed if the interaction occurred in-person.

Consideration of online delivery of clinical services incorporating clinical hypnosis begins with attention to the principle of *primum non nocere* (first, do no harm). This is not an antiquated term, nor should its implications and ramifications for ASCH's future actions be taken lightly. All seasoned clinicians know, at least implicitly, that any intervention with another person has, by definition, an impact. We cannot hide behind the truth that sometimes, even with our best intentions, we can do harm. Thus, in decisions about when, how, and for whom we consider engaging in clinical hypnosis work through remote connections, the question is not whether we will succeed in absolutely avoiding inducing harm, but whether, through considered actions, we minimize unintended negative consequences (*nocere*) while maximizing the clinical benefit for the people with whom we engage with hypnotic practices, whether as clients/patients or as professional trainees.

ASCH is attempting to operate in an online world in which an appreciation of the complexities of treating people and/or training clinicians is overlooked or overtly disregarded, irrespective of whether clinical hypnosis is involved. ASCH and its membership cannot ethically afford for expediency of access or other alluring dimensions of online service delivery to be substituted for safeguarding those essential characteristics of the clinical encounter, regardless of the therapeutic setting, that assure care for the whole person, in all their uniqueness and complexity.

Clinical hypnosis training offered through ASCH-ERF, particularly at the Level I (Fundamentals) and Level II (Intermediate) levels, relies heavily and appropriately on supervised small group experiential practice to acquire the foundational skills upon which proficiency in the use of clinical hypnosis relies. For technical reasons as well as due to the absence of direct observational opportunities, online

training limits the ability for faculty facilitated or supervised training to attend to the non-verbal and other subtle cues expressed by the "subject" and "operator" in online training. This limits access to what research has found to constitute 80%, or more, of the "information" involved in interpersonal communication (Mehrabian, 1971).

Nevertheless, faced with the scope of the pandemic and the cascade of effects arising from it, for continuity of healthcare services delivery, for access to professional training, and for the continued survival of ASCH as a society involved in the development and delivery of clinical hypnosis training, an ethical and thoughtful response to the challenges ASCH faces is required. In that light, the ASCH Ethics Committee offers the following guidelines that begin with a distinction between when to incorporate clinical hypnosis into active treatment with clients vs. how ASCH should proceed with the training of clinicians new to the field of clinical hypnosis.

Guidelines for Remote Delivery of Clinical Services

The Ethics Committee recognizes that being able to continue to offer clinical services that incorporate clinical hypnosis into treatment during a national and international crisis is necessary. We do, however, believe limitations and constraints around what and for whom clinical hypnosis could be offered in the absence of face-to-face, in-person contact needs to be strongly recognized.

- Clinical hypnosis exists along a continuum of approaches that seek to evocate comfort and calm to modulate and modify complex features of client/patient character and personality.
- Before choosing to incorporate clinical hypnosis into telehealth treatment, clinicians should consider the following:
    - that the client/patient has an in-person, thorough assessment of the client/patient that's been conducted by the clinician ***before*** the use of clinical hypnosis remotely is considered;
    - that a strong client/patient-clinician relationship has been established ***before*** introducing clinical hypnosis remotely;
    - whether the client/patient has ready access to support and assistance from the clinician or other appropriate readily available support in the event of an unexpected adverse response; and
    - whether the clinician had the opportunity to incorporate hypnosis into treatment with the client/patient ***prior*** to telehealth use of hypnosis so that they and the client/patient are familiar with the client/patient's level of hypnotic responsiveness, suggestibility, and ability to re-alert and re-orient themselves.
- Clinical hypnosis should not be casually introduced into the treatment of an individual with whom the clinician has not yet had the opportunity to conduct an in-person assessment of their needs and history during which attention to non-verbal response patterns would be directly accessible. Remote connections limit access to such cues, which increases the risk of unintended and unobservable adverse reactions.
- Incorporation of clinical hypnosis with clients exhibiting conditions that increase the likelihood of dissociation, abreaction, or various dysregulated response patterns, should only be utilized in carefully structured contexts that presume the therapist-client/patient relationship is very well established and the focus of the treatment session is narrowly focused and well delineated.
- The Ethics Committee suggests that when remote connections between clinician and client/patient are the sole means of connection, the clinician consider incorporation of clinical

hypnosis primarily for general purposes relating to evocation of comfort, calm, and self-soothing.

- Caution needs to be exercised when considering the use of clinical hypnosis in the telehealth-based treatment of individuals exhibiting:
    - phenomena associated with complex trauma;
    - character disorder;
    - psychotic features;
    - cognitive deficiencies (e.g., developmental challenges);
    - cultural differences/English language limitations;
    - conditions involving active drug and/or alcohol abuse impacting cognitive arousal, attentional focus, and mental tracking abilities;
    - limited access to additional personal support or supportive services, or the absence of an appropriate and agreed upon plan involving the ability to obtain ready access to the clinician has been clearly established in the event that an adverse reaction is experienced;
    - prior experience with hypnosis that was non-productive, disconcerting, disturbing, or resulted in an untoward response; and
    - inadequate understanding of, and absence of accurate conceptions regarding, clinical hypnosis and the process in which it might be integrated into the treatment covenant.
- When working with children, whose imaginative abilities include a more fluid general reality orientation, additional caution needs to be exercised when incorporating clinical hypnosis into treatment to assure appropriate re-alerting and re-orientation.
- The possible vicarious, unintended, evocation of trance involving parents in the immediate environment of the child client/patient during intervention including clinical hypnosis, with clinician lack of awareness must be remembered and resolved appropriately.
- The clinician ought to consider allowing for extended time in sessions to assess and assure adequate re-alerting and re-orientation, including allowing for the use of measures designed to assess this (e.g., Howard, H., 2017).
- The clinician engaging in utilizing clinical hypnosis remotely ought to consider familiarizing themselves with the literature on conducting clinical services remotely (selected references are offered below).
- Obtaining an appropriate signed (electronically or otherwise) consent form from the patient/client relating to the use of clinical hypnosis remotely.
- The clinician ought to evaluate the strength and stability of the platform through which treatment incorporating clinical hypnosis would be conducted to minimize the risk of "hypnoticus interrupticus" occurring in the midst of the clinical encounter.

Guidelines for Conducting Clinical Hypnosis Training Remotely

The Ethics Committee recognizes that conducting training remotely is a new challenge for the organization, and all the more so for the Level I (Fundamentals) and Level II (Intermediate) trainees. Deferral of training until such time that it is deemed safe to return to "live" training is not viable on several fronts: 1) It is not clear that post-pandemic, the world of training will automatically revert to the pre-pandemic baseline. 2) It is not clear that ASCH is financially able to sustain the loss of revenue such a deferral would entail. 3) Given ventures with online learning occurring in many fields, it is quite possible that the delivery of high-quality online learning/training represents a significant

growth opportunity for ASCH. This invites us to augur well into how online learning and training could be conducted ethically, effectively, and profitably.

- The Ethics Committee sees online training as more or less ready to proceed, depending on the level of training and intended audience (i.e., most ready with Advanced level participants and least ready with Level 1 participants).
- At present, online training would be easiest to conduct at the Advanced level of training. ASCH has already established a growing library of online content. In addition to offering the varied content now available, ASCH can consider developing more extensive training that is longer in length (e.g., Regional Workshops are 4-day trainings), training that is cumulative and topic focused (e.g., a series of shorter offerings that can be participated in collectively or that operate as stand-alone offerings, but which, if enrolled in as a series could lead to greater proficiency and clinical depth in that specific clinical approach/model or the treatment of a specific condition).
    - Advanced training could proceed with the fewest concerns regarding breaching ethical standards.
    - If experiential content is to be part of an Advanced level presentation, especially if it is pre-recorded, consideration of the type of experience offered and means for re-alerting/reorienting need to be woven in.
    - If Advanced level training is "live," (e.g., a live webinar), opportunities for participants to call in with concerns are available, but the need for careful consideration of the nature of experiential practices with an eye to potential adverse reactions remains.
- Online training limits the ability to offer facilitated and supervised training with the degree of detail and nuance that is available through in-person interactions. This is especially relevant to Level I training, where a significant percentage of the training time is devoted to supervised, facilitated small group practice to cultivate the observational and interactive skills upon which clinical hypnosis proficiency rests.
- We acknowledge that 21.5 hours of online learning is not equivalent to 21.5 hours of in vivo learning such as is involved in Level 1 workshops at this time.
    - To rush into operation online learning of new trainees without also offering an equivalent means of obtaining adequate supervised training risks "graduating" clinicians with substandard skills. In turn, this risks the delivery of subpar clinical hypnosis services to clients/patients, which is not only potentially injurious to them but to the reputation of ASCH, as well.
    - For Level I and Level II training, we suggest exploration of delivery online of didactic portions of the curriculum, upon completion of which a certification of completion of didactic learning, for example, could be earned.
        - Attainment of Certification in clinical hypnosis would await completion of online and/or in vivo 1:1 consultation such as is currently utilized by some clinicians completing requisite hours toward their certification status.
        - Preparation and availability of experienced faculty to offer the 1:1 consultation, fee structure, time frames or time limits for completion of the consultation, and determination of means to establish adequate skill attainment would still need to be determined.
        - The certification process described above for trainees who have completed the didactic portion of training in clinical hypnosis might as part of their individual consultation submit video of their interactions with a subject (with

whom they are competent to work without hypnosis) could enable careful review and feedback in lieu of in-person consultation.
    - The Ethics Committee continues to explore how to best structure faculty-facilitated, small group training in all workshop tracks so as to assure clinical training adequacy around the following issues:
        - participant safety through the use of efficacious methods of re-orienting and re-alerting of participants; and
        - available faculty resources to attend to the needs of any participants who may experience an untoward response during or in response to any portion of the workshop experience.
- While live, in-person training remains unavailable, Level I or Level II online training could entail hypnosis skills that emphasize hypnotic language structures (e.g., pacing, leading, ratification commentary), self-hypnotic practices where "use of self" could be a substitute for hetero-hypnosis, alert hypnosis methods, metaphor generation, evocation of client/patient comments that afford precious clinician feedback regarding the client/patient's phenomenological experience (i.e., having the subject talk with the operator), and other hypnotic processes less reliant on direct observation by the clinician of the subject's and operator's behaviors.
- An ethical consideration in ASCH training is that the "end user" is not solely the clinicians we train but the clients who are the beneficiaries of those we train. Telehealth may well prove to be an important means of delivering necessary services to people otherwise unable to travel to locations where services are otherwise available. Therefore, the ethical principle of beneficence needs to be kept in mind as ASCH thinks through how to offer clinical hypnosis-informed services via telehealth when the alternative may well be no services.
- Beneficence (doing good) is contrasted with nonmaleficence (not doing harm) and constitutes a tension ASCH needs to balance as we continue to evolve new standards of practice regarding the use of remote learning to train clinicians and to deliver clinical services to deserving clients/patients.
- In a response by the Editor to a letter published in the American Family Physician, K. Lin, MD, PhD, places the phrase *primum, no nocere* in a larger and more historically accurate context. The fuller meaning is that we should all strive toward two goals when working with clients/patients. We should seek to help, but when we can't, we ought to at least seek not to make things worse. That, it seems, is the ethical standard that needs to guide ASCH decision-making around the challenge of helping, when the usual path to the offering of help is blocked, and where an alternative path (telehealth) may help or hurt. Let's proceed wisely.

Below are select references pertaining to telehealth and therapy generally, as well as to the use of clinical hypnosis in telehealth specifically.

References

American Psychological Association (2013). *Guidelines for the practice of telepsychology*. American Psychologist. Vol. 68(9), 791-800. DOI: 10.1037/a0035001

Appel, P.R., Bleiberg, J. & Noiseux (2002).*Self-Regulation Training for Chronic Pain: Can It Be Done Effectively by Telemedicine?* Telemedicine Journal and e-Health.361-368.http://doi.org.tcsedsystem.idm.oclc.org/10.1089/153056202605074 95

Backhaus, A., Agha, Z., Maglione, M. L., Repp, A., Ross, B., Zuest, D., Rice-Thorp, N. M., Lohr, J., & Thorp, S. R. (2012). Videoconferencing psychotherapy: A systematic review. Psychological Services, 9(2), 111–131. https://doi.org/10.1037/a0027924

Baker, D. C., & Bufka, L. F. (2011). Preparing for the telehealth world: Navigating legal, regulatory, reimbursement, and ethical issues in an electronic age. Professional Psychology: Research and Practice, 42(6), 405–411. https://doi.org/10.1037/a0025037

Banyan, G., and Giles, C. S., (2020). National Guild of Hypnotists: Recommended Standards for Online Hypnotism. National Guild of Hypnotists, Inc., Privately Printed

Barnett, J. E., & Scheetz, K. (2003). Technological advances and telehealth: Ethics, law, and the practice of psychotherapy. Psychotherapy: Theory, Research, Practice, Training, 40(1-2), 86.

Bromberg, P. M., (2014). Standing in the spaces: Essays on clinical process, trauma, and dissociation. New York, NY. Psychology Press, Taylor & Francis Group.

Fleming, D. A., Edison, K. E., & Pak, H. (2009). Telehealth ethics. Telemedicine and e-Health, 15(8), 797-803.

Forester-Miller, H., & Davis, T. (2016). *Practitioner's guide to ethical decision making* (Rev. ed.). Retrieved from http://www.counseling.org/docs/default-source/ethics/practitioner's -guide-to-ethical-decision-making.pdf

HIPAA Guidelines on Telemedicine (2020). www.hipaajournal.com/hipaa-guidelines-on-telemedicine.

Howard, H.A. (2017) Promoting Safety in Hypnosis: A Clinical Instrument for the Assessment of Alertness, American Journal of Clinical Hypnosis, 59:4, 344-362, DOI: 10.1080/00029157.2016.1203281

Jonsen, A. R. (1978). Do no harm. Annals of Internal Medicine. 88(827-832).

Kaplan, B., & Litewka, S. (2008). Ethical challenges of telemedicine and telehealth. Cambridge Quarterly of Healthcare Ethics, 17(4), 401-416.

Kock, N. (2005). *Media richness or media naturalness? The evolution of our biological communication apparatus and its influence on our behavior toward e-communication tools.* IEEE Transactions on Professional Communication. Vol (48(2): 117-130.

Kvedar, J, & Agboola, S. AHRQ Commentary. (2020). 7 Tips for Including Patient Safety in Telemedicine Programs. https://mhealthintelligence.com/news. (See Addendum)

LeCroy, K. (2001). The Lie of Primum non Nocere. American Family Physician. Dec 15. 64(12): 1942.

Mehrabian, A. (1971). Nonverbal communication. In *Nebraska symposium on motivation*. University of Nebraska Press.

Pathipati. A.S., Azad, T.D., & Jethwani, K. (2016). Telemedical Education: Training Digital Natives in Telemedicine. J Med Internet Res, Jul 12.

Simpson, S., Morrow, E., Jones, M., Ferguson, J., & Brebner, E. (2002). Video-hypnosis—The provision of specialized therapy via videoconferencing. Journal of Telemedicine and Telecare, 8, 78 – 79. DOI:10.1258/135763302320302136

Original 5/16/20
Updated 6/7/20