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A Spiral Curriculum for Hypnosis Training

David M. Wark
St. Paul, MN
Daniel P. Kohen
University of Minnesota

Although hypnosis has been used for centuries, there are few reports of systematic, professional training. The most thorough codification of instructional content is the *Standards of Training in Clinical Hypnosis* (SOTCH) (Elkins & Hammond, 1994), endorsed by The American Society of Clinical Hypnosis (ASCH), and The Society of Clinical and Experimental Hypnosis (SCEH) for annual workshops. This curriculum is organized around two assumptions: training is presented to adult professionals who know their own objectives; and each participant has a favorite learning style that should be accommodated. The workshop follows the content and time recommendations of the SOTCH. Some content is scheduled with spaced opportunity for practice. Concepts are organized in a spiral pattern, then presented and reviewed several times, each time in more detail, and in ways that accommodate different learning styles.

Keywords: Educational standards, spiral, growth, training, learning styles

Hypnosis Training

The practice of hypnosis has a long history. The use of hypnotically augmented treatment by the priest practitioners of Egypt is documented in 2000 BC (Breasted, 1930). For a thousand years from 500 BC to 500 AD in Asia Minor the sleep temples of Askelepios were centers for hypnotic practice (Brier, 1981). Mesmer's "magnetic therapy" was widely practiced as general medicine and anesthesia as late as 1850. Yet in all that time, while the techniques were well described, there was no available core of information or methods to train practitioners and pass on the skills.

American professionalization of hypnosis began in 1949 when Jerome Schneck, M.D., founded the Society of Clinical and Experimental Hypnosis (SCEH). His goal was to give a scientific, academic basis for hypnosis practiced by advanced clinicians and researchers (Schneck, 1993). The SCEH meetings were developed and intended to discuss and publish research, not provide training. The popular "three day workshop" format

Copies of other spiral schedules and all the small group objectives and performance checklists are available from the senior author. Request reprints from:

David M. Wark, Ph.D.
1313 5th Street SE
Minneapolis, MN 55414
wark@mister.ucs.umn.edu

was later created by Milton Erickson, MD and others who, in 1957, founded the American Society of Clinical Hypnosis (ASCH) (Watkins, 1998). In 1958 the American Medical Association recommended that physicians receive training in hypnosis during medical training. But that recommendation was never widely followed, perhaps in part because no recommended or guiding curriculum was offered. Most hypnosis training for medical, dental, mental health and other professionals continues to be conducted in relatively brief intensive regional or national workshops. Commonly the participants are licensed or in graduate-level training for their professions. These workshops are offered by inspiring entrepreneurs, consortia of practitioners, universities or professional schools (Oster, 1998), or professional associations (Dane & Kessler, 1998).

In other countries the situation is different. For example, national professional groups offered multi-year hypnosis training in Holland (Dane & Kessler, 1998) and Australia (Stanley, Rose, & Burrows, 1998), and Israel has a 1984 Law of Hypnosis mandating 35 hours of instruction covering 10 required topics chosen by a parliamentary committee. Applicants other then psychiatrists and psychologists take 25 more hours in psychopathology, psychotherapy and learning theory. (G. Golan, personal communication, July 7, 2002). Until recently, however, there was no international, coherent, consensual standard for content.

The Standards of Training in Clinical Hypnosis

In 1992 D. Corydon Hammond, Ph.D., and Gary Elkins, Ph.D., began a project to delineate the content of professional education in clinical hypnosis (Elkins & Hammond 1994). They queried 242 internationally recognized hypnosis clinicians, teachers and scientists of all theoretical orientations. Of the 109 respondents, 31% had earned diplomate status in medical, dental or psychological hypnosis. (At the time, the social work diplomate had not yet been formalized). These knowledgeable and advanced participants were first asked the total number of hours, beyond degree training and licensure, they would recommend be devoted to workshop and classroom training in hypnosis before beginning professional practice. They were also asked to recommend the ideal number of minutes to be devoted for each of 57 topics, and whether the topic should be presented at a beginning, intermediate, or advanced level. The pooled and integrated responses showed that the respondents supported instruction organized into separate 20-hour basic and intermediate programs, with specific recommended topics. Hammond and Elkins then developed learning objectives along with recommended content for each topic at each level. This important work was published as the *Standards of Training in Clinical Hypnosis* (SOTCH), a significant advance in the delineation of adequate professional training (Elkins & Hammond 1998).

The SOTCH is an organized compendium of information about hypnosis. It is divided into 15 areas for the introductory level, and 11 at the intermediate, each level encompassing 20 hours. The introductory level covers topics such as Definition, History and Theories (Area 1), Myths and Misperceptions (Area 2), Assessment (Area 3) Hypnotic Phenomena (Area 4), Principles and Process of Induction and Realerting (Area 5), Concepts of Susceptibility (Area 9), Ethics (Area 14), etc. At the Intermediate level, some areas are Advanced Inductions, Hypnotic Strategies for concerns such as pain, anxiety, phobic and habit disorders, etc.

ASCH, SCEH and The Minnesota Society of Clinical Hypnosis (MSCH), one of

the larger ASCH component societies, formally voted to follow the standard in their introductory and intermediate workshops. At that point the question for the organizations' training directors was "With what assumptions, and following what theory might the information and technique in the SOTCH be organized?" This paper gives the rationale for such an organized training curriculum.

Assumptions for the Spiral Curriculum

A fundamental assumption of the spiral curriculum design is that participants are adult professionals. Although they lack information about hypnosis, they have other medical, dental and mental health knowledge and skills. The hypnosis information and techniques to be learned must "make sense'' and be applicable to the way the participants practice. The implication for training is that instructors must show respect for the expertise of the participants, and keep presentations, didactic or experiential, focused on clinical practice (Bloom, 1993, 2001).

The second guiding assumption is that everyone can learn in many different ways. Every workshop participant has a favorite, most natural and most effective way to learn. Metaphorically, travelers can live in many different places, but "there's no place like home". By analogy, a task for hypnosis instructors is to arrange instructions so that each participant has a chance to grasp and integrate new material in the learning style that feels most "like home".

One of the best implementations of learning style flows from the work of David Kolb, who investigated active learning, applicable to development of new skills such as using hypnosis (Kolb, 1984). According to his conceptualization, learners go through four active steps in developing new knowledge. The steps are repeated over and over as a student learns. The first step is a learner's *concrete experience* of a new skill (for example, the experience of being induced into hypnosis). The second stage is *reflective observation* of the experience (noticing how hypnosis influences thoughts and perceptions and emotions). Third comes *abstract conceptualization* about the experience, to create a summary or theory (creating an expectation or personal truth about hypnosis). The final step is *active experimentation* to test out or extend the application of one's theory to new situations (e.g. self-hypnosis to achieve calmness and anesthesia). The active experimentation leads to a new concrete experience, and the process continues to spiral up, getting more complex with each iteration.

Kolb summarizes his work using two conceptual dimensions that cross each other. One dimension explains how a learner first grasps new information. The learning can be done by concrete experience, or by abstract conceptualization. This dimension seems to accommodate the "touching/feeling to thinking" axis. The other dimension defines the way learners make use of newly grasped information. Some do it by observing carefully, some by hands on testing and manipulation.

Kolb has documented a range of learning styles (Kolb, 1984). Some people, for example, operate best by combining concrete experience and reflective observation. Kolb calls that the "diverger" style because such learners are most comfortable taking a concrete experience and looking at it from many perspectives, brainstorming and generating many different ideas, often original and competitive. Such people tend to study or work in the liberal arts and psychology. Another group of learners is labeled "assimilators", people who are particularly comfortable starting with abstract

conceptualizations, and using reflective observation to generate an overall theory that assimilates many observations. These people tend to study or work in math, chemistry or economics. Other identified learning styles are the "convergers" who take abstract conceptualizations and move by active experimentation to produce new results. They tend to work as engineers. Finally, Kolb cites the "accomodators", who like to start with concrete experience and actively experiment, often with other people, to come up with cooperative new experience. Not surprisingly, "accomodators" like to work in business.

There are some important implications of Kolb's work for teaching hypnosis. Consider the documented links between learner style and occupation. In any group of hypnosis workshop participants, there are likely to a preponderance of divergers (psychologists, social workers and mental health specialists) and assimilators (physicians, dentists, nurses, and health science workers). Consider how these participants best learn a fundamental skill such as doing a hypnotic induction. Both divergers and assimilators transform what they learn by reflective observation of good induction demonstrations. But they prefer to get their initial learning in different ways. Assimilators will be more comfortable starting with an abstract summary of the principles of induction, such as a didactic lecture on pacing and leading. Divergers, on the other hand, will be more comfortable starting with a concrete experience of a hypnotic phenomenon. They may learn better in a group induction and a suggestion for levitation. The same considerations apply to the way participants assess susceptibility, elicit hypnotic phenomena, frame suggestions, teach a client to do self-hypnosis etc. The material is best presented in different ways. Of course, even though in the workshop there may be a preponderance of participants with one of two learning styles, all four will be represented. One clear implication is that instruction should be presented using all the styles, so that each learner can spend some time comfortably "at home".

Implementing the Spiral Curriculum

The Spiral Curriculum is planned to stay within the 20 hour SOTCH, provide instruction through all the learning styles, in a sequence that starts at the basic and spirals up to more advanced application. As an example, consider SOTCH Area 5, Principles and Process of Induction and Realerting; Principles of Formulating Hypnotic Suggestions. In the SOTCH, Area 5 contains 4 objectives and extensive content. Allotted time is 150 minutes. Here are the printed objectives and recommended contents:

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 of realerting from hypnosis.

C. Identify and define at least 6 principles of hypnotic induction and suggestions.

D. Describe at least 4 types of hypnotic suggestion.

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, re-alerting) along with the importance of removing suggested effects and techniques for re-alerting. 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. (For the complete list, see Hammond & Elkins, 1994, pp. 6-7.)

The question is how best to present that material in a fashion that supports various learning styles, and builds slowly to facilitate transfer to professional practice. The sample schedule, presented in Table 1, starts with some background on hypnosis, to give a cognitive overview. Then, using the SOTCH instructional objectives, the content is presented in the same order that it would be used by a clinician, from preliminary steps for induction (myths and misperceptions) to termination and relapse prevention (teaching clients to do self-hypnosis). The actual teaching is presented in a way that accommodates many learning styles. After the entry level concepts are presented, instruction is "spiraled" up to the next level with appropriate review, adding more complexity and detail, again in a way designed to reach participants regardless of learning style. This process then continues, reviewing and adding levels and details to related concepts.

The solution involved breaking Area 5 into parts, and interspersing content from Area 8, (small group practice), Area 9 (deepening) and Area 7 (demonstration of elicited hypnotic phenomena). The content from Area 5 was actually spread over two days, involving all the learning styles, and spiraling into more and more complex skills. The same spiral process is applied to basic ideas like "susceptibility" "teaching self-hypnosis" and "eliciting hypnotic phenomena".

At Spiral Level 1 the concepts of "induction", "pacing", "leading", and "informing clients" are introduced. There are lectures, exercises, demonstrations, and eventually a supervised practice group, in which participants get time to role play "operator", "client" and "observer". There are specific Goals for Small Group Practice, Session 1 and a checklist for evaluation. The checklist is a very behavioral inventory of steps taught at Spiral Level 1. A participant observer in the small group observes each pair, fills out the checklist, and gives it to the learner in the "operator" role.

At Spiral Level 2 earlier concepts are reviewed and practiced and the concept of "deepening" is presented and used in Small Group Practice Session 2, again with

Table 1: Sample Introductory Workshop Schedule

SOTCH Area	Topic	Condensed Objectives	Workshop Time	Format	Kolb Learning Style
1	Definition, History and Theory	Define, discuss history and theories	0:30	Lecture	AC
2	Myths and Misconceptions; Memory	List myths, summarize research	0:30	Lecture	AC
3	Presenting to Patient; Informed Consent	Present hypnosis clearly; ask for consent	0:30	Lecture	AC
9	Susceptibility (1 of 3)	List lifetime changes and training research	0:15	Lecture	AC
4	Hypnotic Phenomena	Group induction and suggestion for catalepsy	0:30	Induction	CE
9	Susceptibility (2 of 3)	List “stages” and client population differences	0:15	Lecture	AC
4	Hypnotic Phenomena	Group induction and suggestion for time distortion and catalepsy	0:30	Induction	CE
5	Principles of Induction (1 of 4)	List steps of induction and alerting; breath pacing exercise.	1:00	Exercise	CE
6	Demonstration of Induction	Observe four different models	1:15	Model	RO
5	Principles of Induction (2 of 4)	List principles and identify in role play	0:30	Model	RO
5	Principles of Induction (3 of 4)	Get client attitude re: hypnosis	0:30	Role Play	AE
8	Supervised Small Group Practice 1	Induction and alerting	1:30	Exercise	CE, AE
9	Susceptibility (3 of 3)	Ways to deepen—Tart Scale of depth	0:30	Exercise	CE, AE
8	Supervised Small Group Practice 2	Induction, deepen, alert	1:30	Exercise	CE, AE

SOTCH Area	Topic	Condensed Objectives	Workshop Time	Format	Kolb Learning Style
13	Susceptibility Scales	Know value of scale and sample items Group exercise	0:30	Model	CE
15	Integrating Hypnosis into Practice	Hypnosis and children	1:00	Lecture	AC
10	Self-Hypnosis	Demonstration Exercise: Doing self-hypnosis	0:45	Model	RO, CE, AE
5	Formulating Suggestions	List types of suggestion and ways to use hypnotic language	0:30	Lecture	AC
7	Demonstration of Elicited Phenomena	Observe volunteers demonstrating	1:00	Model	RO, CE
8	Supervised Small Group Practice 3	Induction, deepen, elicit phenomena and alert	1:30	Exercise	CE, AE
11	Treatment Planning	When and how to use hypnosis	1:00	Lecture	AC
12	Managing Resistance	Variables and techniques	0:45	Lecture	AC
15	Integrating Hypnosis into Practice	Discucsion and exercise by specialization	3:30	Demo	CE, AC
14	Ethics, Professional Conduct and Certification	Standards for use of hypnosis	0:30	Lecture	AC
		Total Instructional Time:	20:15		

AC = Abstract Conceptualization AE = Active Experimentation CE = Concrete Experience RO = Reflective Observation

explicit goals and a checklist.

Finally, in Spiral Level 3 certain hypnotic phenomena are discussed and demonstrated. In the third small group the participants again practice induction and deepening, but add an exercise in eliciting at least one advanced hypnotic phenomena. And again they get feedback.

Evaluation

The spiral curriculum is a multifaceted system of objectives, contents, levels, formats and learning styles. Thus, there is no single, overall way to do evaluation. That said, it is possible to report partial, formative findings. This report contains two pieces of evaluation: the participants' subjective perception of their ability to measure a client's susceptibility and the observer's objective report of certain behaviors in the small group practice sessions.

For the subjective evaluation, participants were given an evaluation form immediately after certain instructional sessions. The form listed each objective of the session, and a 5 point scale that asked how well they felt they could meet that particular objective. The scale ran from 0 ("I'm not sure I know how to do it at all") to 5 ("I can do it very well"). For the measure reported here, the participants were asked how well they thought they could "Measure a client's response to hypnosis". The mean subjectively perceived ability to evaluate susceptibility increased over three sessions ($M = 2.63$, 3.00, 3.53, $p < .01$). It seems reasonable to conclude that the participants spiraled up in their understanding of the concept of hypnotic susceptibility and their perceived ability to use the information.

A different source of evaluation is the behavior checklist that observers filled out during the small group practice sessions (see Table 2). Many different types of evaluation could be made from those data. A compilation of samples of Session 2 checklists indicates that 55% of the participants used 4 or more different suggestions for deepening, 60% paced their suggestions to client exhalations, and 88% did an early and late test for depth. These limited findings indicate the potential to evaluate many aspects of the spiral curriculum workshop.

Discussion

A spiral is not an instructional blue print. There is no ideal or perfect one that will work for every participant and every workshop. We chose to teach Area 1 (history and theory) and Area 2 (myths and misperceptions) early in the workshop, in order to develop a common informational base for the participants. But the same material could arguably be presented last, as a review. Spirals can be arranged in many ways.

A spiral is a metaphor, a pattern, a concept that may apply to conceptions of human physical growth or even to intellectual and psychological development. In this paper, the metaphor is applied to a type of education and gives a rational set of guidelines for planning. The notion reminds the instructor that there are more tasks than simply lecturing about objectives and content. There are participants in the classroom, on both sides of the lectern, and the needs of everyone should be accommodated, flexibly and adaptively. Just as instruction flows from fact to fact, participants can flow from concept to implementation to new insights. The spiral notion, conceived grandly, encourages the instructor to consider all the levels of instruction that may be traversed

Table 2: Level 2 check list for small group practice

Practice Session 2 Induction, Deepening and Realerting

Techniques for developing good rapport

Yes___ No___ Comfort—Operator asks about favorite relaxing places

Yes___ No___ Safety—Operator asks about images to avoid

Yes___ No___ Operator uses the client's primary representation system (visual, auditory or kinesthetic)

Test depth of hypnosis with Tart Scale

Yes___ No___

Deepening suggestions (check all that are used)

___Going to another place: Elevator, stairs, gallery, forest, mountain

___Flexing muscles

___Visual imagery of another place

___Breathing

___Direct suggestion i.e. "Go deeper"

___Ideomotor suggestion i.e. hand drifting down

___Other_____

Suggestions paced to exhalations to suggest depth

Yes___ No___

Retest to confirm depth changes

Yes___ No___

Realerting strategy

Yes___ No___ Operator directs realerting by suggestions paced to inhalation

Yes___ No___ Operator suggests subject direct the realerting process

in a classroom.

The SOTCH and spiral are helpful when more then one person teaches in a workshop. Instructors who come later in the sequence would know the objectives and content their earlier colleagues presented, and be able to do a competent review before moving to higher levels of the spiral. Supervisors in the small group practice sessions all use the same check list and format, so that participants do not have to worry about adjusting to new styles (Wark & Kohen, 1998). As such faculty and participants alike have a working familiarity with the whole workshop.

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