A Survey of Members of ASCH, SCEH, and Division 30, and if They Reported Using Hypnosis to Treat Depression

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A telephone survey was conducted with randomly selected members of the American Society of Clinical Hypnosis (ASCH), the Society for Clinical and Experimental Hypnosis (SCEH), and the Psychological Hypnosis Division of the American Psychological Association (DIV 30). The purpose of this study was to explore the extent to which hypnosis society members reported using hypnosis to treat major depression. A 3-group MANOVA did not find any differences among the groups, and all members reported using hypnosis to treat depression. (Sleep and Hypnosis 2001;3(4):152-168)

Key words: *survey, ASCH, SCEH, Division 30, treatments, depression*

INTRODUCTION

The purpose of this study was to explore the extent to which hypnosis society members reported using hypnosis to treat major depression and their levels of favorability about the use of hypnosis for major depression. An additional goal was to examine similarities and differences between members of these organizations.

Members were surveyed from the following three organizations: The American Society of Clinical Hypnosis (ASCH), the Society for Clinical and Experimental Hypnosis (SCEH), and the Psychological Hypnosis Division of the American Psychological Association (DIV 30). Data were gathered on the application of hypnosis, demographic characteristics, and attitudes about the use of hypnosis.

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Accepted November 21, 2001

The specific questions asked of survey participants are the following:

1. Are there differences among ASCH, SCEH, and DIV 30 members with regard to age, gender, the number of years they have been in their profession, and whether they were using hypnosis at the time the survey was conducted?
2. Are there differences among ASCH, SCEH, and DIV 30 members with regard to the state/region in which they practice, highest degree attained, primary employment setting, primary occupation, and primary psychological and hypnosis theories to which they adhere?
3. Are there differences among ASCH, SCEH, and DIV 30 members with regard to percentage of clients with whom they use hypnosis (if they use hypnosis), the number of years they have used hypnosis, their attitudes about the use of hypnosis for major depression, and whether they use hypnosis for major depression?
4. Are there differences among ASCH, SCEH, and DIV 30 members with regard to whether

their use of hypnosis has increased, decreased, or stayed the same over the years and the purpose for which hypnosis is used?
5. Of those members who use hypnosis for major depression, how do they use, monitor, and determine the effectiveness of hypnosis for major depression and associated symptoms, and what symptoms of major depression do they treat?
6. Of those who were using hypnosis at the time the survey was conducted, what percent have had difficulty obtaining reimbursement from insurance companies for hypnosis procedures?
7. Of those professionals who were not using hypnosis in their practice, what percent have used it in the past, how long had they used it, why did they stop using it, for what did they use hypnosis, what are their attitudes about hypnosis for major depression, and would they use hypnosis for major depression?
8. For what disorders and symptoms do hypnosis society members believe hypnosis should and should not be used?

Hypnosis Societies within the United States

In the U.S., three prominent hypnosis societies have emerged over the past 50 years: the Society for Clinical and Experimental Hypnosis (SCEH), the American Society for Clinical Hypnosis (ASCH), and the Psychological Hypnosis Division of the American Psychological Association (DIV 30).

SCEH

SCEH was founded in 1949 because researchers wanted a nationwide hypnosis organization to help unite those who were publishing their work (1). SCEH is an organization of nurses, social workers, dentists, psychologists, psychiatrists and other physicians who are dedicated to scientific inquiry and the conscientious clinical use of hypnosis. Members provide workshops, lectures, publications, and other teaching activities to educate health care professionals, academicians, students, and the general public about the nature and ethical uses of hypnosis and other phenomena (SCEH Membership Information Brochure, 1998).

ISCH

The International Society for Clinical and Experimental Hypnosis (ISCEH) developed as an outgrowth of SCEH and eventually became simply the new International Society for Hypnosis (ISH) (1-3).

There were approximately 1,445 members in ISH in 1999 and approximately 450 members in SCEH in 2000.

ASCH

The American Society of Clinical Hypnosis (ASCH) developed through the efforts of Milton H. Erickson in 1958. Erickson had numerous followers and wished to develop an organization that could better meet his and their needs.

Division 30 (DIV 30) of the American Psychological Association in 1969 with an emphasis on hypnosis and hypnotherapy. Adelm Mahran, from the Psychology Department at the Long Island University, is considered the division's founding chairman (4).

There are several membership types within Division 30. To be a member of the division, one must have a doctoral-level degree in psychology (e.g., Ph.D., Psy.D., or Ed.D) or an equivalent degree. To be an associate member of the division, one must possess a master's-level degree in psychology (e.g., M.A., M.S., M.Ed,) or an equivalent degree. To become a Fellow of the division, one must first be a member of the division, and then must be nominated to become a Fellow. A fellow is an individual who has made an outstanding contribution to the science and profession of psychology (C. Silva, personal communication, July 6, 2000).
DIV 30 is devoted to exchanging scientific information, advancing teaching and research, and developing high standards for the practice of hypnosis. Its mission statement specifies that it brings together psychologists and other professionals interested in scientific and applied hypnosis to encourage the professions to devel-

op new and innovative clinical interventions and research methods, and evaluate current treatment approaches.

Hypnosis in Other Countries

In Italy hypnosis is better known and used as an adjunct strategy rather than a primary treatment therapy (5). In Norway, there is a strong push to integrate clinical and experimental hypnosis, which is partially facilitated by the secure position hypnosis has in university graduate, postgraduate, and doctoral training programs (6).

Heap (7) indicates that in Britain and Ireland, "there is an urgent need for the establishment of a core consensus of learned wisdom and opinion on the matter of hypnosis" (p. 28). There are four societies in the U.K. and Ireland for professionals, but there are dozens of private organizations of lay hypnotists. Heap says that in Ireland there are no laws concerning hypnosis and in Britain there is only one, the Hypnotism Act of 1952, that was created to license stage hypnosis shows.

Both clinical and experimental hypnosis are strong in Australia (8). Australian perspectives on hypnosis have been more interactionist, placing importance on both cognitive and social processes. Hypnosis is commonly taught in medical, dental, and psychology schools. The primary hypnosis training program is conducted by the Australian Society of Hypnosis. Unfortunately, there are no governmental regulations concerning the practice of hypnosis. This means that the Australian Society of Hypnosis has had the ongoing challenge of ensuring the ethical and responsible practice of hypnosis (8).

Castaneda (9) indicates that numerous problems exist in the field of hypnosis in Mexico. Specifically, there are rivalries and splits between prominent figures that have led to the establishment of small, individual groups, there is a lack of hypnosis publications and resources, and the Mexican health and education authorities have failed to officially recognize hypnosis as a treatment modality.

Clearly, the value of hypnosis is recognized around the world. Unfortunately, hypnosis professionals in various countries struggle with some of the same issues. Most notable are a lack of governmental regulation and rivalries and splits between prominent researchers in the field. These problems and divisions will continue to keep professionals and researchers focused on clarifying and explaining the properties of hypnosis rather than conducting experimental studies. In addition, researchers and practitioners have constantly had to deal with biases against the use of hypnosis (10,11).

METHODS

Sample

Altogether, 150 members of ASCH, SCEH and Division 30 listed in the 1997 to 2000 membership directories agreed to participate in the telephone survey. Surveying took place from mid-November 2000 through January 2001.

The 150 survey participants were placed in one of three groups (ASCH, SCEH, and DIV 30). A pilot study was conducted on a sample of randomly selected professionals belonging to the Wisconsin Society of Clinical Hypnosis and on randomly selected Ph.D.-level hypnosis practitioners advertising in the 1999–2000 Milwaukee, Wisconsin, and the Oshkosh, Wisconsin, Yellow Pages of Wisconsin.

The ASCH, SCEH, and DIV 30 directories and lists were cross-referenced. Those who were members of more than one of the three organizations were excluded from the random selection process.

After the exclusionary process, all members remaining within the lists and directories were assigned a number. A random numbers table was then used to select potential participants. Altogether, 256 individuals were randomly selected from the 1998 ASCH directory, the 2000 SCEH membership list, and the 1997 DIV 30 membership directory. Sixty-two members of ASCH, 67 members of SCEH, and 127 members of DIV 30 were randomly selected. Members were selected on two separate occa-

sions. The first random selection took place in November 2000. Letters of transmittal were sent to 150 randomly selected society members, 50 from each of the three organizations. By early December 2000, it became apparent that members of ASCH and SCEH were easier to locate and/or contact than members of DIV 30. This was to some extent expected as DIV 30 had the oldest membership directory that we were using. Therefore, another 110 society members, most of whom were from DIV 30, were randomly selected so there would be approximately the same number of participants in the three primary groups (ASCH-only, SCEH-only, and DIV 30-only).

The second set of letters of transmittal was sent in December 2000. Errors in member selection were later discovered making the actual number of second-round, randomly selected potential participants to be 106 instead of 110. Therefore, a total of 256 members were randomly selected from the three membership lists and directories.

Fifty-two out of 256 letters of transmittal were returned in December, January, or February and were unable to be forwarded or were returned with a note that the individual was deceased. However, 23 of the 52 individuals located using the Internet or directory assistance were reached by phone, and completed the survey even though the letter of transmittal had not been forwarded to them. In many cases, it was not until they were reached by phone that we were able to ascertain that we indeed had the correct individual.

The letter of transmittal stated the purpose of the study, that the survey would be conducted within a certain period of time, that they had been randomly selected from the membership records supplied by ASCH, SCEH, or DIV 30, that membership personnel from the hypnosis organizations were aware of the study, and that members from other organizations were going to be surveyed as well. They were also told that while information about members would be compared and contrasted to the data from the members of the other organizations, data from the individual participants would remain anonymous.

Data Collection Procedure

Data were collected via the Hypnosis for Major Depression Telephone Survey. A copy of the questionnaire is in Table 1. The interviews were conducted by trained researchers. Three paid friends and family members of the lead researcher assisted with the data collection. During training in November 2000, the researchers learned the study's purpose, studied hypnosis terminology, were instructed in interviewing strategies, and observed the interviewing process and data collection and coding procedures. Many potential problems and obstacles were discussed before surveying began and throughout the process.

Methods of Data Analysis

All of the questions on the Hypnosis for Major Depression Telephone Survey could be answered by responding yes or no, 1 to 5 on a Likert scale measuring favorability, or by a short answer. Data collection and coding were completed less than 12 weeks from the time surveying began. Data coding occurred at the same time the interviews were being conducted. Comparisons were conducted following the entry of data. Two coding checks were conducted.

RESULTS

Question 1 – Are there differences among ASCH, SCEH, and DIV 30 members with regard to age, gender, the number of years they have been in their profession, and whether they were using hypnosis at the time the survey was conducted?

Participants in the three primary groups (ASCH, n=36; SCEH, n=35; and DIV 30, n=35) totaling 106 participants were compared on two dependent variables using a three-group MANOVA. The dependent variables included age and length of occupation. No significant differences were found among the groups on

the dependent variables, Wilks's= .965(4,206) =.451, p>.05.

Gender

Regarding gender, considering all 106 participants in the three primary groups (ASCH, SCEH, and DIV 30), 67 (63.2%) members were male and 39 (36.8%) members were female.

Specifically, 20 (55.6%) members of ASCH were male and 16 (44.4%) were female. Twenty-two (62.9%) members of SCEH were male and 13 (37.1%) were female. Twenty-five (71.4%) members of DIV 30 were male and 10 (28.6%) were female. The differences between the groups were not significant using a chi-square test, which compared observed frequencies to expected (equal) frequencies for Gender by Group cells (degree of freedom=2, n=106), value=1.925, p=.382. There were no significant differences, chi-square (2,106)=1.925, p=.382.

Question 2 – Are there differences among ASCH, SCEH, and DIV 30 members with regard to state/region in which they practice, highest degree attained, primary employment setting, primary occupation, and primary psychological and hypnosis theories to which they adhere?

State/Region of Practice

Participants were listed as practicing either in the Northeast, West, Midwest, South, or outside the continental U.S. The Northeast includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. The West includes Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming. The Midwest includes Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin. The South includes Alabama, Delaware, Washington D.C., Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia. The states outside the Continental U.S. include Hawaii, Alaska, and the U.S. Virgin Islands.

One hundred and six participants in the primary groups (ASCH—36, SCEH—35, and DIV 30—35) were compared using a chi-square test. Overall, there were no significant differences between the groups in terms of state/region of practice using a chi-square test, which compared observed frequencies to expected (equal) frequencies for State/Region by Group cells. There were no significant differences, chi-square=7.628, p=.471. Sixteen (15.1%) practiced in the West, 31 (29.2%) practiced in the Midwest, 24 (22.6%) practiced in the South, 33 (31.1%) practiced in the northeast, and 2 (1.9%) practiced outside the Continental U.S.

Degree

In terms of highest degree attained and considering all 106 participants in the three groups (ASCH, SCEH, and DIV 30), 79 members (74.5%) had a Ph.D. in psychology, counseling, or a related field, 6 (5.7%) had an Ed.D., 4 (3.8%) had a Psy.D., and 17 (16%) had a master's degree or its equivalent. The differences between the groups were not significant using a chi-square test, which compared observed frequencies to expected (equal) frequencies for Degree by Group cells. There were no significant differences, chi-square (6,106)=6.388, p=.381.

Primary Employment Setting

In terms of primary employment setting, all 106 in the three primary groups (ASCH, SCEH, and DIV 30) were placed in one or more of the following categories: inpatient mental health facility, outpatient clinic, private practice or private group practice, school setting (primary, secondary), university, hospital, prison system, other state government position, and other. Because many participants gave more than one response, frequencies and cross-tabulations were conducted.

The majority, 92 out of 106 respondents (86.8%), in the three groups combined (ASCH,

SCEH, and DIV 30 [n=106]) indicated they were working in an outpatient facility, in a small group practice, or were in private practice. Specifically, 34 out of 36 (94.4%) of those who were in the ASCH group, 31 out of 35 (88.6%) in the SCEH-only group, and 27 out of 35 (77.1%) in the DIV 30 group were working in an outpatient facility, in a small group practice, or were in private practice.

Primary Occupation

Respondents in the three groups (ASCH, SCEH, and DIV 30 [n=106]) were placed in one or more of the following primary occupations: clinical or counseling psychologist (including psychotherapist and psychoanalyst), school psychologist, social worker, university professor/researcher, medical doctor, other, or retired within the last four years. Frequencies and cross-tabulations were conducted. A total of 83 out of 106 (78.3%) in the three primary groups combined (ASCH, SCEH, and DIV 30 [n=106]) reported that they primarily functioned as a clinical or counseling psychologist, psychotherapist, or psychoanalyst. Specifically, 25 out of 36 (69.4%) members in the ASCH group, 26 out of 35 (74.3%) in the SCEH group and 32 out of 35 (91.4%) in the DIV 30 group indicated that they worked clinically as a psychologist.

Primary Mental Health or Psychological Theoretical Approach

Out of 106 in the three groups combined (ASCH, SCEH, and DIV 30), 104 (98.1%) indicated that they had a primary mental health approach to which they adhered. Many practitioners gave two or more approaches.

Specifically, all 36 ASCH group members (100%) indicated that they had a primary mental health or psychological approach to which they adhered. The most frequently mentioned were an eclectic style (n=16, 44.4%); cognitive-behavioral approaches (n=14, 38.9%); and analytic, psychodynamic, and insight-oriented approaches (n=13, 36.1%).

All 35 (100%) SCEH group members indicated that they had a primary mental health or psychological approach to which they adhered. The most frequently mentioned were cognitive-behavioral approaches (n=17, 48.6%), and analytic, psychodynamic, and insight-oriented approaches (n=12, 34.3%).

Thirty-three out of 35 (94.3%) DIV 30 members indicated that they had a primary mental health or psychological approach to which they adhered. The most frequently mentioned were cognitive-behavioral approaches (n=15, 45.5%), analytic, psychodynamic, and insight-oriented therapies (n=11, 33.3%), and an eclectic style (n=11, 33.3%).

Primary Hypnosis Approach

Seventy-five out of 106 (70.8%) in the three primary groups combined (ASCH, SCEH and DIV 30) indicated that they had a particular hypnosis theoretical approach to which they adhered. Participants were placed in one or more of 15 possible hypnosis theoretical approach categories.

Specifically, 27 out of 36 (75%) ASCH group members indicated that they adhered to a primary hypnosis theory. Ericksonian Hypnosis was the most frequently mentioned approach, and was indicated by 16 out of the 27 (59.3%). Other approaches mentioned by at least two practitioners include the utilization model, strategic, paradoxical, autogenic training, nonauthoritarian or permissive (but not Ericksonian), metaphors or storytelling, expectancy theory, cognitive-behavioral hypnosis, imagery, that which is not mainstream, pragmatic, behavioral, eclectic and/or integrative, and ego-state or ego-strengthening approaches.

Twenty-four out of 35 SCEH group members (68.6%) indicated an adherence to a particular hypnosis theoretical approach. Seven (29.2%) out of the 24 practitioners mentioned Ericksonian hypnosis. Neo-dissociation was mentioned by 5 (20.8%) practitioners. Other approaches indicated by two or more SCEH group members include an eclectic or integrative approach, hypnoanalysis, sociocognitive theory, social learning, relaxation, permissive, and self-hypnosis.

Twenty-four out of 35 (68.6%) DIV 30 group members indicated an adherence to a particular hypnosis theoretical approach. Seventeen (70.8%) out of 24 mentioned Ericksonian hypnosis. Other approaches indicated by two or more practitioners include ego state therapy, the Locksmith Approach, neo-dissociation, sociocognitive theory, traditional, existential, and an eclectic and/or integrative approach.

Question 3 – Are there differences among ASCH, SCEH and DIV 30 members with regard to the percentage of clients with whom they use hypnosis (if they use hypnosis), the number of years they have used hypnosis, their attitudes about the use of hypnosis for major depression and whether they use hypnosis for major depression?

Those within the three groups (ASCH, SCEH, and DIV 30), who indicated they were using hypnosis at the time the survey was conducted (n=90), were compared on three dependent variables using a three-group MANOVA. The variables include: the percentage of clients with whom hypnosis had been used, number of years they have used hypnosis, and their level of favorability about the use of hypnosis for major depression. A 5-point Likert favorability scale was used to determine the attitude of society members about the use of hypnosis for major depression. Responses were rated as very favorable, favorable, undecided, unfavorable, and very unfavorable. Sixty-one out of 90 participants (67.8%) indicated that they felt favorable or very favorable about the use of hypnosis for major depression.

A significant difference among groups was not found using a MANOVA test, Wilks's =(6,170)=.873, p=.069. Specifically, 23 (74.2%) of ASCH group members indicated that they used hypnosis with 20% or more of their clientele, compared to 16 (50%) of SCEH group members, and 11 (40.7%) of DIV 30 group members. The largest number of SCEH group members and DIV 30 group members indicated that they used hypnosis with fewer than 10% of their clientele.

Use of Hypnosis for Major Depression

Regarding whether the hypnosis society member was using hypnosis for major depression, and considering all 90 participants in the three groups (ASCH, SCEH, and DIV 30) who indicated they were using hypnosis at the time the survey was conducted, 54 (60%) indicated they were using hypnosis for major depression. Specifically, 22 members out of 31 (71%) in the ASCH group, 15 out of 32 (47%) members of the SCEH group, and 17 out of 27 (63%) members of the DIV 30 group indicated they were using hypnosis for major depression.

Question 4 – Are there differences among ASCH, SCEH, and DIV 30 members with regard to whether their use of hypnosis has increased, decreased, or stayed the same over the years and the purpose for which hypnosis is used?

Rate of Use—Increased, Decreased, or Stayed the Same

All 90 participants in the three groups (ASCH, SCEH, and DIV 30), who were using hypnosis at the time the survey was conducted, were asked whether their use of hypnosis has increased, decreased, or stayed the same over the years. A total of 39 out of 90 (43.3%) indicated their use of hypnosis has increased over the years. The three groups (ASCH, SCEH, and DIV 30) were compared using a chi-square test. In the ASCH group, 17 (54.8%) indicated their use of hypnosis has increased, compared to 11 (34.4%) in the SCEH group and 11 (40.7%) in the DIV 30 group. Overall, there were no significant differences between the groups in terms of rate of use using a chi-square test (8,90)=7.202, p=.515.

The Purpose for Which Hypnosis is Used

Of those within the ASCH, SCEH, and DIV 30 groups who were using hypnosis, 83 out of 90 (92.2%) treated three or more conditions, diagnoses or symptoms. Responses were placed within 78 possible categories. The categories covered a

wide range of symptoms and disorders for which hypnosis could potentially be used. Frequencies and cross-tabulations were conducted.

The most common disorders and symptoms treated by each group include the following:

ASCH group—20 out of 31 (64.5%) treated addictions and habits, 23 (74.2%) treated anxiety, 14 (45.2%) treated depression and associated symptoms, 11 (35.5%) treated pain, and 11 (35.5%) treated abuse issues.

SCEH group—24 out of 32 (75%) treated addictions and habits, 21 (65.6%) treated anxiety, and 18 (56.3%) treated pain.

DIV 30 group—19 out of 27 (70.4%) treated addictions and habits, 13 (48.1) treated anxiety, 11 (40.7%) treated pain, and 10 (37%) treated abuse issues.

Question 5 – For those members who are currently using hypnosis for major depression in their practice, how do they use, monitor, and determine the effectiveness of hypnosis for major depression and associated symptoms, and what symptoms of major depression do they treat?

Number of Sessions Needed

Respondents were asked the number of hypnosis sessions they thought were necessary when treating major depression. Many respondents gave more than one answer. Responses were placed in one of six possible categories: just one session, 2 to 5 sessions, 6 to 10 sessions, 11 or more sessions, depends on the needs of the individual, and other response. Frequencies were determined.

Out of 52 respondents to the question, of those in the three groups combined, who indicated they were using hypnosis for major depression and associated symptoms, 1 (1.9%) professional mentioned that he/she typically used only one session to treat symptoms of major depression, and 9 (17.3%) indicated that they used between 2 and 10 sessions. Forty-two (80.8%) indicated that it depended on the client's needs. Sixteen out of 21 (76.2%) in the ASCH group, all 14 (100%) in the SCEH group, and 12 out of 17 (70.6%) in the DIV 30 group indicated that the number of sessions varied and depended on the client's needs and what else was being done to treat the depression.

Effectiveness

Regarding the question of how practitioners know if hypnosis has been effective for their clients suffering from major depression, frequencies and cross-tabulations were conducted. Thirty-nine out of a total of 52 (75%) respondents to the question in the ASCH, SCEH, and DIV 30 groups indicated that clients report to them either the same day or in subsequent sessions that they have experienced an improvement in or an alleviation of symptoms. Clients may report that they have experienced an increase in activity level, that they may have stopped or decreased negative self-talk, and so on. Seventeen out of 20 (85%) in the ASCH group, 13 out of 15 (86.7%) in the SCEH group, and 16 out of 17 (94.1%) in the DIV 30 group indicated that they rely heavily on client self-report, either during the same day/session, or in subsequent sessions. The following indicated that they see and note the improvement in the client and use this as a primary means for monitoring the effectiveness of hypnosis: ASCH—13 out of 20 (65%), SCEH—8 out of 15 (53.3 %), and DIV 30—8 out of 17 (47.1%).

Scales and Instruments

Frequencies and cross-tabulations were conducted for the questions regarding whether or not scales or instruments were used to help the practitioner know if hypnosis had been effective and the types of scales or instruments used. Out of 52 respondents to the question, 22 (42.3%) indicated that they use or have used scales or instruments to help them determine whether hypnosis was effective for their clients with major depression. Specifically, 7 out of 20 (35%) ASCH group members, 9 out of 15 (60%) SCEH group members, and 6 out of 17 (35.3%) DIV 30 group members indicated that they have used some type of scale or instrument

to help determine whether hypnosis has been effective. The most commonly used instrument for all three groups was the Beck Depression Inventory, used by 16 out of 22 (72.7%) practitioners who indicated they used scales or instruments to help them determine whether hypnosis was effective for major depression.

Monitor

Frequencies and cross-tabulations were conducted for the question regarding over what period of time the effectiveness of hypnosis is monitored for major depression. Twenty-eight out of a total of 51 respondents to the question (54.9%) indicated that they monitored the effectiveness throughout treatment, session by session, or weekly throughout treatment. Specifically, 13 out of 21 (62%) ASCH group members, 8 out of 13 (61.5%) SCEH group members, and 7 out of 17 (41.2%) DIV 30 group members indicated they monitored the effectiveness of hypnosis session by session throughout the course of treatment.

Symptoms Treated When Working with Major Depression

The most frequently treated symptoms when working with major depression as expressed by 52 respondents in the three primary groups combined (ASCH, SCEH, and DIV 30) using hypnosis for major depression include the following: 59.4%—negative cognitions, and so forth; 58%—anhedonia, low energy level, excessive or extreme tiredness, psychomotor retardation, decreased energy and activity level and vegetative symptoms; 44.9%—low self-esteem, low ego strength; 37.7%—sleeping difficulties, insomnia, trouble falling asleep, hypersomnia; 23.3%—feelings of hopelessness and/or helplessness; 21.7%—anxiety and/or panic; 13%—both physical and mental stress and tension; and 10.1%—trauma.

Many practitioners responded that (a) categorization and diagnosing are not necessarily good, (b) they would only work with clients on the above symptoms if the client was stabilized on medication, and (c) hypnosis should be used cautiously with clients with depressive symptoms.

Question 6 – Of those who were using hypnosis at the time the survey was conducted, what percent have had difficulty obtaining reimbursement from insurance companies for hypnosis procedures?

Of those in the ASCH, SCEH, and DIV 30 groups who were using hypnosis at the time the survey was conducted, there were 89 respondents to the question as to whether the practitioner has had insurance reimbursement difficulties for hypnosis procedures. Twenty-three (25.8%) out of the 89 respondents to the question indicated that they have had difficulties receiving reimbursement from insurance companies for hypnosis. Sixty-six (74.2%) indicated that they have not had difficulties. However, of those who indicated they had not had difficulties, many gave an explanation as to why they had not had difficulties. Regardless of whether they indicated that they had difficulties with insurance companies, 79 out of 89 (88.8%) gave ways that they get around disputes or difficulties. Specifically, 47 out of 89 respondents (52.8%) indicated that they have not had difficulties with insurance companies because they (the practitioner) view hypnosis as an adjunct approach, and they bill under general or standard psychotherapeutic approaches or procedures for diagnoses and symptoms. Therefore, they either avoid disclosing that hypnosis has been utilized or they list it as being utilized along with other more readily accepted treatment approaches. Sixteen out of 89 (18%) indicated that they never or rarely mention to managed care companies that they are using hypnosis because hypnosis is viewed negatively or with skepticism. Twelve (13.5%) indicated that they only work with self-pay clients.

Question 7 – Of those professionals who were not using hypnosis in their practice, what percent have used it in the past, how long had

they used it, why did they stop using it, for what did they use hypnosis, what are their attitudes about the use of hypnosis for major depression, and would they use hypnosis for major depression?

Because of the small number contained within these groups (n=16), frequencies were determined for each question.

Past Use

All 16 respondents in the three primary groups who were not using hypnosis at the time the survey was conducted indicated that they used hypnosis in the past. This included 5 ASCH members, 3 SCEH members, and 8 DIV 30 members.

Years Used

Regarding the question of how many years the practitioner had used hypnosis, 1 indicated 1 to 5 years, 3 indicated 6 to 9 years, 8 (50%) indicated 10 to 14 years, 1 indicated 15 to 19 years, 1 indicated 20 years or more, and 2 gave other responses that were not categorizable.

Why Use Was Discontinued

Considering the total number of 15 respondents to the question of why the practitioner stopped using hypnosis, 8 (53.3%) indicated that they changed jobs and were no longer practicing clinically or they were not practicing clinically to the extent that they had been and, therefore, they discontinued using hypnosis. Several practitioners gave more than one reason. Other reasons for discontinuing use of hypnosis included but were not limited to the fact that there was a change in clientele and/or the clientele were no longer requesting hypnosis (n=2, 13.3%), that the practitioner developed other interests (n=4, 26.7%), and that they started using more informal hypnosis strategies including visualization and other relaxation approaches and fewer formal inductions (n=2, 13.3%) and, therefore, they did not consider themselves to be using hypnosis.

Use of Hypnosis

Regarding conditions, diagnoses, and symptoms for which the practitioner had used hypnosis, and considering there were 15 respondents, the most frequently cited responses were addictions and habits (n=11, 73.3%); anxiety, panic, and posttraumatic stress disorder (n=8, 53.3%); pain—both acute and chronic (n=7, 46.7%); and depression (n=4, 26.7%).

Favorability

Of those who were not using hypnosis at the time the survey was conducted (n=16), 9 (56.3%) indicated they felt favorable about the use of hypnosis for major depression, 5 (31.3%) were undecided, and 2 (12.5%) felt unfavorable.

Would They Use Hypnosis for Major Depression?

Seven (43.8%) out of 16 respondents indicated that, if they were using hypnosis, they would use it for major depression.

Question 8 – For what disorders and symptoms do society members believe hypnosis should and should not be used?

All 150 survey participants were asked for which disorders and symptoms they believe hypnosis should and should not be used. One hundred and twenty-five out of 150 total respondents (83.3%) indicated there were disorders and symptoms for which they felt particularly favorable about using hypnosis. One hundred and thirty-one (87.3%) indicated that there were disorders and/or symptoms for which they believe hypnosis should not be used. The responses of those who were using hypnosis (n=125) and those not using hypnosis at the time the survey was conducted (n=25) are listed separately and are presented in terms of percentages. Most practitioners gave several responses.

Disorders/Symptoms for Which Hypnosis is Favored

Eighty-seven percent of respondents, who were using hypnosis at the time the survey was conducted, indicated they felt favorable about its use for certain disorders and symptoms. Most gave several responses.

The most common symptoms and disorders mentioned include 56.9%—anxiety, fears and phobias; 33%—addictions or habits such as smoking, drinking, overeating, eating disorders, and so on; 32.1%—medical issues such as migraines or pains, surgical healing, preparation or obstetrics; 24.8%—PTSD, traumas, and abuse issues; 19.3%—pain, acute and/or chronic; 12.8%—dissociative identity disorders or multiple personality disorders; and 11%—childhood disorders such as attention deficit disorder, attention deficit hyperactivity disorder, overanxiousness, sleeplessness, and so on. Of the 25 survey respondents who were not using hypnosis at the time the survey was conducted, 16 (64%) indicated that they felt favorable about using hypnosis for certain disorders or symptoms. The most common disorders or symptoms were 37.5%—academic issues; 37.5%—behavior control, addictions and habits, and so on; 18.8%—reducing or changing negative cognitions; 18.8%—dissociative identity disorders or multiple personality disorders; and 12.5%—abuse, trauma, and PTSD.

Disorders/Symptoms for Which Hypnosis is Not Favored

The most frequently mentioned disorders or symptoms for which hypnosis is not favored included, but were not limited to the following: 66.7%—psychoses, delusions, hallucinations, schizophrenia, other thought disorders (schizophrenia was specifically mentioned by 17.4% of the practitioners); 39.4%—certain personality disorders such as borderline personality disorder, antisocial personality disorder (excluding dissociative identity disorder); 17%—for memory retrieval or repressed memories and/or forensic cases; 16.5%—dissociative identity disorder or multiple personality disorder; 11.9%—those suffering from paranoia; 9%—those not easily hypnotizable; 8.3%—alcoholism.

Of those who were not using hypnosis at the time the survey was conducted, 22 out of 25 (88%) gave disorders and/or symptoms for which they believe hypnosis should not be used. The most frequently mentioned were 54.5%—psychotics, delusions or hallucinatory disorders; 36.4%—"other" personality disorders such as antisocial personality disorder; and 31.8% specifically mentioned borderline personality disorders.

DISCUSSION

This study found that among members of ASCH, SCEH, and DIV 30, there were actually very few differences in regard to personal and professional characteristics and beliefs about how hypnosis should be used. Hilgard (4) indicates that the independent societies of ASCH and SCEH serve some functions that DIV 30 serves less well. However, other than the offering of conferences and workshops at the elementary and advanced levels, and the membership levels and types of certification, there appear to be very few "other" differences between the organizations and their members.

Although all three groups were created for distinct purposes between 30 and 60 years ago, it may very well be that the reasons for their remaining separate and distinct no longer exist. At this time, energy may be better spent strengthening the field of hypnosis overall with efficacy research, and so on, instead of strengthening the individual organizations and emphasizing their "distinctiveness." The organizations may be able to champion the merits of hypnosis better if they are united. Cardeña (12) believes hypnosis societies should collaboratively and cooperatively develop brochures to educate the public and other health care professionals about the benefits of hypnosis. Only through a united effort will we be able to educate others for whom hypnosis "remains an exotic and impractical area" (p. 2).

Lewith and Aldridge (13) stated that the

biggest problem with hypnosis research is that there is a fundamental incompatibility between experimental methodology and the nature of hypnosis (10). They indicated that a "true" experiment requires an "objective" approach, which minimizes subjective content. They believe that hypnosis practitioners, on the other hand, look for and foster interpersonal trust and empathy and utilize a personal, individual induction procedure that is sensitive to the momentary changes of the person. The challenge will be for hypnosis practitioners to conduct "true," replicable, experimental studies and meet the individual needs of the clients they serve. Nash (14) states that there are still too many within medicine, psychology and hypnosis who dismiss the importance of research. Schulberg, Katon, Simon, and Rush (15) state that until randomized controlled trials of complementary and alternative treatments such as hypnosis are conducted, they will simply remain intriguing and provocative rather than scientifically founded first-line interventions.

Although this study found that the majority of randomly selected hypnosis society members feel favorable or very favorable about the use of hypnosis for major depression, Torres Godoy (16) indicates that, at the present time, literature on the use of hypnosis for depression remains mostly anecdotal. According to Torres Godoy, the enthusiasm among hypnotherapists who use hypnosis for depression is good but there are no conclusive studies. Schoenberger (17) adds that the number of published studies that show the addition of hypnosis to mental health therapy is small, and many of these studies have methodological limitations. Most are individual case studies, lack randomization, do not have standard treatment protocols, and fail to have a control group.

Hammond (18) states that much research that has been done thus far is flawed, pseudoscientific hypnosis research that ends up being irrelevant and unflattering to the field. He believes we must stop studying and debating theoretical constructs and instead perform rigorous outcome studies to evaluate the value of multicomponent hypnosis treatments. Without a solid research base, hypnosis will not gain support from the health care and funding industries as a bona fide treatment for mental health disorders. Cardeña (12) believes that we should reconsider whether to continue to use the old hypnosis terminology or utilize more precise, easier-to-understand terms. He believes that by identifying more basic processes we will be able to more readily integrate our findings with those of related fields.

Therapy Trends

Tuckfelt, Fink, and Prince Warren (19) believe therapists must accept time-limited psychotherapy and make efforts to become more efficient. This study shows that the largest percentage of hypnosis society members who participated in the study utilize cognitive-behavioral mental health treatment approaches. Tuckfelt et al. believe that even if practitioners do not fully embrace brief therapeutic strategies, they can and should add them to their therapeutic repertoire. The authors believe hypnosis could very well prove itself to be quite valuable considering the many symptoms of major depression for which it can be used. They indicate that the answer is to coordinate one's primary mental health approaches for special populations with special techniques such as hypnosis. This is an excellent time for practitioners to strengthen their approaches, first, because of the huge population who are diagnosed with depression each year; second, because of the huge percentage who are treatment resistant; and third, because of the large percentage who are chronically and comorbidly depressed. Cardeña (12) indicates that in an era of managed care, hypnosis practitioners should be able to communicate with decision makers that hypnosis techniques can accelerate recovery and reduce complications and that this will result in a cost savings.

Peebles-Kleiger (20) adds that the trend toward integrationism in psychotherapy and hypnosis could very well be on the cutting edge of developments for two reasons: (a) because hypnosis has shown itself effectively integrated

in behavioral, cognitive, biological, psychoanalytic, humanistic and systems approaches to mental health treatment; and (b) hypnotic phenomena bridge the emotional, behavioral, cognitive, and neurophysical realms (p. 156). Hypnosis targets multiple mind-body elements of functioning. Finally, the area of hypnosis "could be a leader in the trend toward integrationism and could lead the field on both the clinical and research fronts" (20).

REFERENCES

1. *Schneck JM. The history of the founding of the Society for Clinical and Experimental Hypnosis-A brief communication. The International Journal of Clinical and Experimental Hypnosis 1993:41:169-171.*
2. *Council JR, Gravitz MA, Hilgard ER, Levitt EE. A history of Division 30 (psychological hypnosis). In: Dewsbury DA, ed. Unification through division. Washington, DC: American Psychological Association, 2000:5:59–83.*
3. *Sapp M. Counseling and psychotherapy: Theories, associated research, and issues. Lanham, MD: University Press of America, 1997.*
4. *Hilgard ER. History of research center and professional hypnosis societies in the United States. The International Journal of Clinical and Experimental Hypnosis 1993:41:173-190.*
5. *Loriedo C, Gulotta G. Hypnosis in Italy. In: Hawkins P, Heap M, eds. Hypnosis in Europe. London: Whurr Publishers Ltd., 1998;128-140.*
6. *Nielsen GH, Wormnes B. Hypnosis in Norway. In: Hawkins P, Heap M, eds. Hypnosis in Europe. London: Whurr Publishers Ltd., 1998;158-168.*
7. *Heap M. Hypnosis in Britain & Ireland. In: Hawkins P, Heap M, eds. Hypnosis in Europe. London: Whurr Publishers Ltd., 1998;17-36.*
8. *Bryant RA. Hypnosis in the world: Australia. Psychological Hypnosis-A Bulletin of Division 30. 2000:9:6-10.*
9. *Castaneda M. Hypnosis in the world: Mexico. Psychological Hypnosis-A Bulletin of Division 30. 2001;10:5-6.*
10. *Sapp M. Hypnosis, dissociation, and absorption: Theories, assessment, and treatment. Springfield, IL: Charles C. Thomas Publisher, Ltd., 2000.*
11. *Sapp M, Hitchcock K. Harvard Group Scale with African American college students. Sleep and Hypnosis 2001;3:111–117.*
12. *Cardeña E. Message from the president: End of a term and a modest proposal for an agenda. Psychological Hypnosis-A bulletin of Division 30. 2001;10:1–3.*
13. *Lewith GT, Aldridge D. Clinical research methodology for complementary therapies. London: Hodder & Stoughton, 1993.*
14. *Nash MR. The status of hypnosis as an empirically validated clinical intervention: A preamble to the special issue. International Journal of Clinical and Experimental Hypnosis, 2000;48:107-112.*
15. *Schulberg HC, Katon WJ, Simon GE, Rush AJ. Best clinical practices: Guidelines for managing major depression in primary medical care. Journal of Clinical Psychiatry 1999;60(Suppl. 7):19-26.*
16. *Torres Godoy PH. The use of hypnosis in posttraumatic stress disorders, eating disorders, sexual disorders, addictions, depression and psychosis: An eight-year review (part two). The Australian Journal of Clinical Hypnotherapy & Hypnosis 1999;30:73-85.*
17. *Schoenberger NE. Research on hypnosis as an adjunct to cognitive-behavioral psychotherapy. The International Journal of Clinical and Experimental Hypnosis 2000;48:154-169.*
18. *Hammond D. Guest editorial: The need for clinically relevant research. American Journal of Clinical Hypnosis 1998;41:2-9.*
19. *Tuckfelt S, Fink J, Prince Warren M. The psychotherapists' guide to managed care in the 21st century. Northvale, NJ: Jason Aronson Inc., 1997.*
20. *Peebles-Kleiger MJ. Contemporary psychoanalysis and hypnosis. International Journal of Clinical and Experimental Hypnosis 2001;49:146-165.*

Appendix

Researcher Initials _____ Date___________ Respondent Code # _____

Hypnosis for Major Depression Telephone Survey

Introductory Statement—"Hello, my name is __ I'm conducting a telephone survey on the use of hypnosis for Major Depression and other disorders and symptoms. This study is being conducted in partial fulfillment of a dissertation related to hypnosis for Major Depression for the University of Wisconsin - Milwaukee. May I have a few minutes of your time to ask you some questions about your use of hypnosis?"
Yes No Reason for **not** wanting to participate ______________________________
REMEMBER! We also need data from those who no longer use hypnosis. (If NO,thank him/her and end conversation.)

I Personal and Professional Information

A. Membership Data

1. "What organization/s are you a member of?" SCEH, ASCH, Division 30, or None (circle all that apply)

2. "How many years have you been a member of each?" __________

B. Demographics and Profession

3. "Would you tell me your age?" ___ _

4. Gender M F (interviewer either circles or asks if unsure)

5. "What is your occupation?"______________________________________

6. "How long have you been a ________________________?"

7. "What state do you practice in?"__________________________

8. "What is the primary employment setting in which you work?" (circle)
inpatient facility outpatient clinic school hospital prison system private practice
other:____

9. "What is the highest degree you've attained?" ______________________

C. Theory Questions

10a. "Do you have a particular mental health or psychological theoretical approach to which you adhere?" Yes No

10b. (If yes) "Can you tell me what it is?"________________________________

11a. "Do you have a particular hypnosis theoretical approach to which you adhere?" Yes No

11b. (If yes) "Can you tell me what it is?" ____

II. Practice and Beliefs

12. "Are you currently using hypnosis in your practice?" Yes No
If Yes to question 12, go to page 2. If NO to question 12, go to page 3.

A. Yes Responders to Question 12. Respondent Code #

13. "With what percentage of clients do you use hypnosis in your practice?" __________

14. "How many years have you been using hypnosis in your practice"? ----_____________

15. "Has your use of hypnosis **increased, decreased or stayed the same** over the years?" (circle or underline response)

16. "For what conditions, diagnoses, or symptoms do you use hypnosis?"

17. "How do you feel about the use of hypnosis for major depression?" (Circle)
Very Favorable Favorable Undecided Unfavorable Very Unfavorable

18. "Would you tell me why you feel __________ about the use of hypnosis for major depression?"

19a. "Do you use hypnosis with patients/clients with **major** depression?" Yes No Other Response
[If yes, continue with 19b, and finish all qs. If no, jump down to 21a and the 22 questions]

19b. (If yes to 19a) -"How many hypnosis sessions would you say are typically necessary when treating someone with major depression?"______________________

19c. (If yes to 19a) - "What symptoms do you treat when working with someone with major depression?"

20a. (If yes to 19a) - "How do you know hypnosis has been effective for your client/s suffering from major depression?"

20b. (If yes to 19a) - "Over what period of time do you monitor the effectiveness of hypnosis for your client/s suffering from major depression?"

20c. (If yes to 19a) - "Do you use any scales or instruments to help you determine whether hypnosis has been effective for your clients suffering from major depression? Yes No

20d. (If yes) - "What are they?"

21a. "Have you had any difficulties with insurance companies paying for hypnosis?" Yes No

21b. (If yes) "Would you explain the difficulties to me?"

22a. "Other than the disorders/symptoms you've already indicated, are there others for which you feel hypnosis is particularly favorable or beneficial"? Yes No

22b. (If yes) "Can you tell me what they are?"

22c. "Are there disorders or symptoms for which you feel hypnosis is unfavorable, contraindicated or should not be used?" Yes No

22d. (If yes) "Can you tell me what they are?"

End of "Yes" responders questionnaire. Thank Respondent for His/Her Time. Write name and address on data sheet if respondent indicates he/she would like to receive a copy of the data.

B. NO responses to question 12. Respondent Code # ______

23. "Have you used hypnosis in the past?" Yes No
(If yes, go to Q. 24 etc. If no, skip to Q. 27a)

24. "Approximately how many years had you used hypnosis?" __________

25. "Could you tell me why you stopped using hypnosis?"

26. "For what conditions, diagnoses or symptoms did you use hypnosis?"

27a. "Do you have any primary hypnosis interests at this time?" Yes No

27b. (If yes) "Could you tell me what they are?"

28. "How do you feel about the use of hypnosis for major depression?" (circle)
Very Favorable Favorable Undecided Unfavorable Very Unfavorable

29. "Would you tell me why you feel __________ about the use of hypnosis for major depression?"

30a. "Would you use hypnosis with someone with major depression?" Yes No

30b. (If yes)"Why?" (If no) "Why not?"

31a. "Other than the disorders/symptoms you've already indicated, are there others for which you feel hypnosis is particularly favorable or beneficial"? Yes No

31b. (If yes) "Could you tell me what they are?"

31c. "Are there disorders or symptoms for which you feel hypnosis is unfavorable, contraindicated or should not be used?" Yes No

31d. (If yes) "Could you tell me what they are?"

End of "NO" responders questionnaire. Thank Respondent for His/Her Time. Write name and address on data sheet if respondent indicates he/she would like to receive a copy of the data.