The use of scripts in Hypnosis Teaching and Practice: Have we been Con – <u>Script</u> – ed

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Is the use of scripts (also called protocols) in clinical hypnotherapy teaching and practice demonstrating professional competence and skills? Specialised knowledge and skills are essential for a profession (Evetts, 2013), but is the teaching of clinical hypnosis/hypnotherapy by scripts and/or the adaptation of scripts truly professional education? Alternately, is it actually a move towards manualising clinical hypnosis/hypnotherapy (M. D. Yapko, 2003, p. 268)? Will developing competencies to devise customised 'hypnotic patter' for each client be the evolutionary step that distinguishes clinical hypnosis from clinical hypnotherapy?

Keywords: *Scripts, Hypnosis, Teaching, Manualised Therapy, Education, Clients*

Introduction

Older views of 'hypnosis' proposed the view that hypnosis was something done to the client and training courses supported that proposition by using standardised scripts based on the client's presenting condition (M. D. Yapko, 2003, p. 65 and 211). Practitioners using clinical hypnosis/hypnotherapy were - and are still often - taught using hypnotic scripts. Scripts are referred to and/or presented within conferences (Murphy, 2016; SCEH, 2013b), training (ACHE, 2015; A. F. Barabasz, Barabasz, & Watkins, 2012; CPMTC, 2016; MM, 2009), associations (ASCH(USA), 2016; SCEH, 2013a), text books (ASCH (USA), 1990; Elkins, 2016a; Hudson, 2009), professional peer reviewed publications (Jensen et al., 2016; Kellis, 2011; Palsson & van Tilburg, 2015), newsletters (Rubin, 2014), and websites (HD, 2016; HS, 2012, 2013; HW, 2016). Research showed that 69% of participants considered scripts an integral part of clinical hypnotherapy training and 65.9% considered rehearsing scripts was beneficial for the practice of clinical hypnotherapy (Cowen, 2015, p. 154). The question that arises, is why are hypnotic scripts used within training courses and presented in various sections of the profession when there is also commentary advising against the usage of scripts (Alter & Sugarman, 2017; Cowen, 2008; M. D. Yapko, 2011)? This duality highlights issues which include aspects of professionalism, professional competence, and may resonate as a potential difference between the practice of clinical hypnosis and clinical hypnotherapy and challenge current educational constructs and the title of the profession's practitioners?

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Nomenclature surrounding the hypnosis/hypnotherapy profession has been undefined for many years. Debate over the profession's and practitioner titles; hypnotist, clinical hypnotist, hypnotherapist and clinical hypnotherapist are not the focus of this paper and readers are encouraged to apply their preferred nomenclature to make ease of reading and allow attention to the use of scripts within the profession.

The use of scripts

Scripts have been used in clinical hypnosis training for many years and are an acknowledged part of the profession. Whether teaching via scripts is the most frequent training methodology requires greater research than is the purview of this paper. It has been argued that 'The Legacy Model' has so deeply entrenched scripts into the profession that irrespective of how the teaching occurred they would remain (Alter & Sugarman, 2017). This raises the question – has the use of scripts become best or standard practice? If so do they adhere to the best practice model of other disciplines such as medicine or psychology (Cowen, 2015; Stagg & Lazenby, 2012)? Do scripts have the support that other 'best practice' models enjoy or are there differing opinions?

There is divided opinion about the role of scripts within clinical hypnosis/hypnotherapy. It is often stated that scripts are only guidelines used to provide an educational pathway for the novice to practice, while published scripts should be adapted/ modified for the individual (Brown & Hammond, 2007; Davis, 2016; Tefikow et al., 2013). There is also the concept that hypnosis is an ancillary tool to the primary treatment strategy and should be integrated with other methodologies (Frischholz & Spiegel, 1983); yet the integration of counselling, psychological and psychotherapeutic skills occupy less space in textbooks and curricula than scripts. In social media and on listserv(s) (Lankton, 2017) the number of requests for scripts/or protocols supports the view that many clinicians find it difficult to transition from scripts and subsequently come to rely on pre-tested scripts (Alter & Sugarman, 2017; Spiegel, 2016).

Whilst some educators, associations and authors embrace scripts, others do not. A recent textbook gives dual

messages stating that the described protocol (a script)

…should be considered as at most a starting point or as "ideas to be considered," and should not be administered (or read to) patients exactly as written without consideration of the patient's specific aptitudes, needs, and treatment goals. At the same time, it may be useful to keep in mind that the wording presented here has been used and edited by a number of very skilled clinicians over many years of protocol development and refinement so it would be worth considering using at least some of the text, as appropriate (Elkins, 2016b, p. 348).

The statement "…and should not be administered (or read to) patients exactly as written without consideration" demonstrates an inherent realisation that trained therapists have difficulty with the aforementioned transition from scripts to spontaneously client-centred patter.

Those who have voiced disagreement with scripts (Barachetti, 2017; Lankton, 2017; M. D. Yapko, 2011) have offered alternative concepts such as where the client becomes the script (McNeilly, 2015) and the practitioner develops the 'client script'. Other comment refers to hypnosis being an emerging science (Alter & Sugarman, 2017; Cowen, 2015) where the practitioner acknowledges the client's unique human experience rather than using scripts which 'pigeon hole' client's as a compilation of signs and symptoms with a medical or psychological diagnosis. Yet scripts continue to be acknowledged, taught, and used that raises the question, why, if scripts are effective and integral, is there this disagreement and duality of guidance. Are scripts answering the trend towards the manualising of therapies (M. D. Yapko, 2003, p. 268)?

Manualised therapy

Manualised treatments have been available for many years and been shown to be efficacious (Galovski, Blain, Mott, Elwood, & Houle, 2012; Havik & Bos, 1996; Henry, Strupp, Butler, Schacht, & Binder, 1993; Strimpfel, Neece, & Macfie, 2016). The adoption of scripts fulfils manualised protocols and specific scripts and hypnotic suggestions appear in the clinician's manual (A. F. Barabasz et al., 2012). Within the literature, comments regarding the tailoring of therapy to the individual abound (A. Barabasz & Christensen, 2006; Galovski et al., 2012; Grover, Hughes, Bergman, & Kingery, 2006; Henry et al., 1993; Strimpfel et al., 2016, p. 123). The manualised therapy literature also denotes that customisation of therapy potentially provides greater efficacy.

The customisation of treatment is echoed by hypnosis literature (A. Barabasz & Christensen, 2006). It is noted that manualised treatments can involve a loss of rapport (Havik & Bos, 1996) and Al-Harasi quotes Braithwaite's conclusion that because script imagery was not negotiated with the client, the overall efficacy of the study may have been reduced (Al-Harasi, Ashley, Moles, Parekh, & Walters, 2010). The literature demonstrates that customisation of scripts has greater efficacy than standardised scripts but the most important is the clinically informed judgement applied when spontaneously client-centred scripts are used (Lankton, 2017).

Although customisation is recommended, scripts are still being advocated. This implies benefits or reduced liabilities (at least to the educator and practitioner) by using scripts. What are these benefits and/or limitations that persuade educators and practitioners to continue using scripts rather than revising curricula and adopting new student performance criteria to develop different skills?

Benefits of scripts

There are several benefits to include scripts in the curricula. These benefits have been surmised from various sources but are not specifically outlined in the literature. Some areas of benefit could include research, education and commercial aspects (e.g., course duration).

Research

Research methodology requires standardisation or protocols and a script fulfils this requirement (Palsson & van Tilburg, 2015). Standardisation (M. D. Yapko, 2003, p. 196) was used in 1959 when Weitzenhoffer and Hilgard developed the Hypnotic Susceptibility Scale (SHSS): Forms A and B. Using designed scripts enables easier integration into research protocols (Askay, Patterson, Jensen, & Sharar, 2007; Elkins, 2016b, p. 181). Some research flexibility was demonstrated when subjects were allowed to pick two favourite suggestions thus individualising their scripts (Tan et al., 2015), however the predominant theme of the script remained. The manualised procedure ensures all clients receive the identical suggestions so the hypnotic methodology can be replicated, validated, and evaluated against other protocols.

Educational

Scripts provide an easy form of teaching and assessment. Few teaching institutions provide sufficient information on which to base specific educational commentary (ACH, 2017; CPMTC, 2016). Instructing students to learn a script or adapt a script from existing protocols taken from a textbook, conference, or website does not require the same competencies as developing a script from the 'client's' specific requirements in a real/simulated consultation. It can imbue a degree of confidence so the beginner does not come to an embarrassing stop during a consultation (McCarthy, 2005). Having students spontaneously construct hypnotic patter within a class situation takes time and providing feedback to each student on their unique contribution in class is time consuming. Requiring students to develop scripts external to class time then presenting them for assessment saves class and lecturer time. This methodology enables efficacious scripts to be learned rote and/or with adaptations thus reducing lecturing and class time. With hypnosis and manualised therapy literature providing research support, script based treatment proselytises both educator and student.

Time expended

Health professionals want to use clinical hypnosis/hypnotherapy, but having limited time they find short courses are far more attractive as they allow for other activities (family and earning) to continue more easily. Scripts are the ideal educational pathway for time poor health professionals to develop the advanced competencies and skills. Training viability is achieved with a script as it is an adjunct to existing skills and enables new graduates to deal with a narrow range of client issues. Working from predetermined therapeutic scripts enables students to follow the existing patter and develop rudimentary skills from which advanced competencies may be developed.

This raises questions regarding the process of moving from initial competencies and skills to advanced competencies and skills. The shorter course duration allows the graduate to

immediately use the newly acquired skills and provides a new income stream while they develop advanced skills.

Research shows efficacy when hypnosis is used symptomatically (HL, 2016a, 2016b; M. D. Yapko, 2003, p. 465) and standardised scripts provide a symptomatic approach which serves the time poor health professionals who prefer to search/ask colleagues for scripts (Lankton, 2017) rather than develop advanced skills.

Marketing Audio/visual products

Using standardised scripts clinical hypnosis/hypnotherapy skills can be extended by making script specific recordings as "pre-packaged tapes and cookbook treatments"(M. D. Yapko, 2003, p. xxviii) available to the general public. Scripts can provide specific suggestions to address the client's issue (Lankton, 2017). Web based repositories for recordings are designed to assist with client issues such as addictions (MM, 2017), cancer (DM, 2016; HJ, 2017), depression (HJ, 2017) and smoking cessation (Eimer, 2017). This provides benefits such as lower cost, ease of access to the purchaser and constant availability of the product to provide an additional income to the provider.

Liabilities of scripts

The use of scripts does contain some liabilities. Some articles outline the liabilities and some are surmised. The liabilities surrounding scripts can be divided into practitioner and client. The attributions of the listed liabilities to client or practitioner in some cases is recognised as a debateable point.

Client

Working from a predetermined script/protocol has inherent weaknesses even if it is adapted for the client (M. D. Yapko, 2003, p. xxviii). The client may experience the practitioner is reading or reciting a rehearsed script which may break rapport with client (Lankton, 2017). In the initial interview the client may be intentionally or unintentionally, led to fit the requirements of the script (Alter & Sugarman, 2017). Some believe that the purpose of a clinical encounter is to activate the clients own resources (Erickson, 1992) and using a therapeutic template may not activate these resources (Alter & Sugarman, 2017). When a script is used the question remains whether the client will be required to adapt themselves to a standardised script ,rather than accede to a personalised program (M. D. Yapko, 2003, p. xxviii).

Practitioner

It has been postulated that standardised scripts reduces efficacy (M. D. Yapko, 2003, p. 46), and likened to "cookbook" treatments. The scripts inherently include assumptions about clients (M. D. Yapko, 2003, p. xxviii) such as all the clients have the diagnostic label (D. Yapko, 2009). Reading scripts distracts the therapist from observing the client (Lankton, 2017) and may result in the therapist requiring the client to adapt to the script (M. D. Yapko, 2003). Requiring the client to adapt to the script may be even more intrinsic when the scripts are selected because the therapist relates to the experiences (Murphy, 2016) rather thing designing the suggestions based upon the client's experiences. Therapy requires non-linear skills, however using scripts promotes linear thinking (Lankton, 2017). Using scripts makes it impossible for the therapist to use the client's perspective (D. Yapko, 2009, p. 20) so the client's unique

qualities may be unavailable within the therapy process (M. D. Yapko, 2003, p. 103)./

Research

Whilst some may consider the use of scripts as manualisation or over standardisation (M. D. Yapko, 2003), the loss of scripts would reduce the capacity for replication of research (Wark, 2008). Scripts allow hypnosis to be integrated into research programs as an adjunct to other methodologies e.g. CBT (Byom, 2010; Castel, Cascón, Padrol, Sala, & Rull, 2012; Uman et al., 2013) which allows some conclusions to be drawn about the efficacy and effectiveness of hypnosis. There is an argument that in the evidenced-based management currently in vogue that empirically supported hypnotherapy has a number of benefits for the profession (Alladin & Alibhai, 2007).

The benefits or otherwise regarding scripts has only recently started to appear in the literature with gusto (Alter & Sugarman, 2017; Lankton, 2017; Sugarman, 2017) although comments have appeared previously. It is imagined the profession's debate will continue for some time however a related concurrent discussion is would relate to the implications of this educational methodology.

Implications of being taught by scripts

It would appear that the teaching of hypnosis holds a unique place in health education as it is taught predominantly by scripts. What other health sciences can claim that position? Various health disciplines have embraced manualisation (Boston & Cottrell, 2016; Fung, 2017; Hunt, van Hooydonk, Faller, Mailloux, & Schaaf, 2017) but only after the underpinning competencies and skills have been established. Within hypnosis the scripts are the underpinning competencies and skills. This raises issues as to what are the implication of this educational bias.

The inclusion of scripts in all aspects of hypnosis training (Brown & Hammond, 2007; CA, 2013; CPMTC, 2016; Eimer, 2006; HS, 2012; Hudson, 2009; Rubin, 2014) conveys implicit messages. These messages include:

> *Hypnosis is easy: use a script;*
> *Rapport is secondary in a therapeutic relationship;*
> *You don't need to engage with clients;*
> *Reading of scripts provides all the necessary therapy; and*
> *The training required is minimal – just read a script.*
> *These messages are reinforced when associations, teaching institutions and other practitioners acknowledge, promote or employ the use of scripts.*

If the therapy is successful, then is it the therapist or the script producing the effect? If it is deemed that the script is the mechanism achieving the results, then the effectiveness of the pre-packaged tapes or a manualised approach become valid treatment considerations. The implications surrounding the use of scripts raises many questions one of which is the 'blind obedience' (M. D. Yapko, 2003, p. xxix) in using scripted routines. Professional practice requires the client to be the focus rather than requiring the client to fit into a pre-determined therapeutic process (M. D. Yapko, 2003).

Professional competency, ethics and scripts

The use of scripts raises issues regarding ethics, professionalism, professional competence and professional responsibility. Referring to counsellors, it is postulated that responsibility for the competency of graduates rests with the educational program (Rust, Raskin, & Hill, 2013). If that proposition is valid, then training programs share the responsibility with other stakeholders within the profession that also promote script based programs. The reliance on scripts promotes the question of why does hypnosis rely so heavily on teaching scripts whilst other mental health disciplines (e.g., counselling, psychology, and psychotherapy) do not rely on this teaching methodology. This paper has not investigated these issues however they are raised as points to consider for further discussion.

Script based techniques also raises the ethical consideration of professional competence and who is responsible for those competencies. Competency has been described as the use of knowledge and skills to achieve a high performance (McDaniel et al., 2014). It is assumed that graduates undertake assessment(s) and are competent upon commencement of clinical practice. However with hypnosis and hypnotherapy training undertaken as Continuing Professional Development (CPD) the same assumptions may not be accurate. Health professionals undertaking short courses are designed to provide additional competencies which augment existing skills. If these hypnosis courses teach script based techniques the ethical use of the techniques depends on the practitioner's and supervisor's professionalism to determine the practitioner's professional competency (McNamara, 2013).

Does the use of script based hypnosis provide higher performance to the practitioner's existing skill set (McClelland, 1973)? Potentially it does but does the use of the scripts actually provide a professional competency? Does the teaching of scripts fulfil professional benchmarks such as "the competencies needed for the practice of one's profession" (McDaniel et al., 2014, p. 410) and is it the basis for professional practice (Alter & Sugarman, 2017)? Would the use of scripts satisfy a definition of competence as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (Epstein & Hundert, 2002, p. 226)? If legally challenged, would an existing health practitioner using a script based approach be accepted as competent? If script based practice is so educationally sound why are other mental health disciplines not incorporating this educational style? At this time these questions are rhetorical but need to be considered within the existing hypnosis educational structures.

Conclusion

There are clearly different attitudes about the use of hypnotic scripts although most experts recommend that scripts be amended to suit the client. The debate regarding the benefits and liabilities of scripts is a necessary debate for the profession. There are concerns that this adaptation is either not occurring or is occurring insufficiently from comments previously referenced. It is an anomaly that sectors of the profession are stating that hypnosis should only be used by recognised health professionals with an existing health degree, yet promote the use of scripts. The use of scripts (even with calls for customisation) does not appear in the same manner in other health training(s). Many experienced therapists who use hypnosis believe there are higher levels of competency involved but if scripts are used then the process emulates a lower professional skill set. If a manualised treatment protocol is all that is required then the required levels of competency to use hypnosis/clinical hypnotherapy are significantly reduced. Diagnosis can be made by an appropriate health professional and then the client can be referred to someone who can apply the manualised protocol – script reading with amendments.

The transition from scripted based education such as inductions, deepenings, and therapy protocols to training the profession to develop 'customised' hypnotic patter will challenge not only those entering the profession but also existing practitioners and educators (Alter & Sugarman, 2017). The preconceptions of an easy script based therapy is being confronted and now needs to be addressed (Alter & Sugarman, 2017). Will this paradigm shift also initiate a name change?

Irrespective of the nomenclature, the move from hypnosis to clinical hypnosis/clinical hypnotherapy requires a clinician to integrate, refine and hone their skills (Hope & Sugarman, 2015). Rather than limiting skills to predetermined scripts with adaptation, the clinician can apply an advanced set of counselling, psychological and psychotherapeutic competencies and skills to develop a therapeutic management methodology customised to the client (Cowen, 2008; Elkins, 2016c; Hope & Sugarman, 2015; D. Yapko, 2009; M. D. Yapko, 2011).

A higher level of skills entails the recognition of human experience not as disease and diagnosis, but as manifestations of individual, uniquely endowed, adaptively self-regulating systems (Alter & Sugarman, 2017). This evolution demonstrates a bridge between clinical hypnosis and psychotherapy. The encompassing of psychotherapy into the clinical hypnosis model signifies a conceptual shift from clinical hypnosis to clinical hypnotherapy. Where clinical hypnosis was perceived by many as an adjunct to other mainstream mental health disciplines, this conceptual and attitudinal shift delineates a major shift to clinical hypnotherapy. The integration of psychotherapeutic techniques into the hypnosis model is not new, it represents a shift which will influence research and the direction of the whole profession (Cowen, 1983, 2003, 2009a, 2009b, 2011, 2014, 2015).

Is our profession able to rise above the entrenched script methodology and educate those entering the profession to embrace new concepts, theories, and methodologies (Alter & Sugarman, 2017; Cowen, 2016; Lankton, 2017; Sugarman, 2017)? Is it time to "….re-examine the role of this "low-tech" tool and return hypnosis to the rank of first-line treatments?" (Jiggins, 2017; Makover, 2016, p. 2). Should we abandon script hypnosis for individualised clinical hypnosis and hypnotherapy? At the very least maybe we should be clear in our use of terminology where hypnosis refers to the use of scripts and clinical hypnotherapy relates to the professional application of higher level hypnotherapeutic skills so that practitioners are clear on what they are offering and clients on what service is being provided. Alas, that is a topic for another day.

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