Teaching Hypnosis in a Family Medicine Residency

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Trainees in a family medicine residency found a three-phase program for learning hypnosis to be valuable in increasing their knowledge of interpersonal communication and their effectiveness as therapeutic agents. Trainees advanced from general introduction to theories and methods of hypnosis and familiarity with hypnotic phenomena, to the practice of hypnosis in specific medical situations with individuals and eventually with groups of patients. Sessions were didactic and experiential, and reading assignments were given at weekly intervals. Trainees served as role models in settings where hypnosis had not been used before, and were able to practice hypnotic techniques clinically even during their beginning phase of training.

The skill of therapeutic communication can be taught through the medium of hypnotic technique. The careful attention that students of hypnosis pay to nonverbal cues, inflections of voice, choice of words, and timing all play an important role in the everyday therapeutic communication of the physician-patient relationship. The following paper contains a description of a course taught at the Duke-Watts Family Medicine Program, a residency training program, and includes a rationale for training the residents, the course outline and objectives, and selected case examples. The implications for using hypnotic technique and the potential impact of the training on the practice are discussed.

Rationale for Training Family Medicine Residents in Hypnosis

Reports of the various uses of hypnosis are increasingly found in the literature.[1-8] The family physician, if trained, is in an ideal position to use hypnosis in many of the reported ways.

The residency training program offered many teaching advantages, for residents have time to study, and the readiness and motivation to learn. A varied patient population in all stages of health and life is a source of case material. The training setting encourages residents to experiment with new approaches to patients, using what they learn about hypnosis in their encounters with patients in the clinic, hospital ward, and Emergency Room. The support of the program faculty, in the form of accessibility to the psychologist for information and feedback, decreases the chance of inappropriate or ineffective work and increases the confidence of the trainees.

Once out of residency, physicians find that support systems are frequently less available and the time for training or supervision is more difficult to arrange. In such an atmosphere, a beginner in hypnosis can easily lose the confidence so critical to success. Confidence, once shaken, is difficult to regain.

The residency setting, then, provides the time, supervision, case material, and peer support which increases the possibility of success in hypnotic training. Such training can result in a competent, confident practitioner with a solid base of expertise that can be maintained in the world of private or group practice, outside of a training center.

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Table 1. The Beginning Course in Hypnosis

Week	Classroom Activity	Reading Assignments	
1	An introduction to hypnosis as a therapeutic modality and a short history of hypnosis is presented. Myths and questions are explored with the group followed by a group induction and discussion.	History of Hypnosis	Crasilneck and Hall[9]
2	The theories of hypnosis are discussed along with techniques of self-hypnosis. Practice session with self-hypnosis.	Theories of Hypnosis	Crasilneck and Hall, Chapter 2
3	Subject and operator teams practice inductions in front of the group for discussion and feedback. Hypnotic capacity in the subject is explored and elicited.	Techniques of Hypnosis	Crasilneck and Hall, Chapter 4 Kroger,[10] Chapters 13-15
4	Practice the specific hypnotic phenomenon as subject and operator: anesthesia, amnesia, hypermnesia, relaxation, levitation.	Precautions in Use of Hypnosis	Crasilneck and Hall, Chapter 20 Kroger, Chapter 19-22
5	A guest practitioner is invited for demonstration and questions. A discussion of the uses of hypnosis in practice includes how to handle ancillary personnel and other observers.	Phenomenon of Suggestion	Kroger, Chapter 2
6	Practice inductions with some specific therapeutic goal in triads of subject, operator, and observer. Discuss the utility of the hypnotic phenomenon.	Selected Reading on Individual Areas of Interest	Either text
7	Practice in pairs using videotape replays to study the fine points of induction and trance behavior. Discuss resistance and facilitation of trance in resistant subject.	Clinical Observations Resistance-Failures	Kroger, Chapter 9 Kroger, Chapter 52
8	Discuss the specific uses of hypnosis in obstetrics, habit control, pain, with children, for anxiety, obesity, etc.	Clinical Applications	Selected readings from either text

Structure and Content of the Course

The specific structure and content of the course evolved from a modification of the American Society of Clinical Hypnosis–Educational Research Foundation workshops. The changes were necessary to accommodate a small homogeneous group of learners, restrictions on available time, and the needs of the practice setting. The courses are divided into Beginning, Intermediate, and Advanced sections. The courses progress from an emphasis on induction and philosophy in the beginning seminar to a more individual, creative approach later.

The course outline for the beginning seminar is shown in Table 1.

Intermediate Course

After the beginning course, the residents are encouraged to take on one patient and proceed to the intermediate level where individual supervision and fine tuning of skills are addressed. Readings in various specialty areas are assigned. Videotapes are made and studied.

Advanced Course

The advanced course covers the Erickson and Rossi book, *Hypnotic Realities*,[11] and Haley's *Advanced Techniques of Hypnosis and Therapy*,[12] and discusses in detail the subtleties of hypnotic work. The advanced group also works to increase their own potential as subjects. Residents may elect to practice group hypnosis with patients sharing a common goal, such as obstetrics and habit control.

Evaluation of the Course

Evaluation of the course is based on the resident's ability to perform the following tasks:

Beginning Course

1. Describe at least three theories of hypnosis and how it works.
2. Demonstrate five different hypnotic inductions with a volunteer subject.
3. Describe the precautions in the use of hypnosis.
4. Demonstrate facility with induction of three hypnotic phenomena with a volunteer subject.

Intermediate Course

1. Select a patient for whom hypnosis is a possible mode of treatment and suggest a course of treatment for the patient.
2. Read about the specific area of treatment and discuss readings with the supervisor.
3. Proceed with the treatment plan after establishing a contract with the patient.

Advanced Course

1. Conduct group sessions for selected patients (pregnancy, smoking, weight loss).
2. Supervise beginning students.

Case Examples

The course outline and evaluation scheme set the stage for residents to learn and use hypnotic techniques. The following examples illustrate some of the ways residents used hypnotic techniques during their beginning phase of training.

Example 1: Dr. B. and a Child. A two-year-old boy presented in the Emergency Room with a laceration of the face. He was crying and frightened and increased his crying at the sight of Dr. B. Dr. B. touched the boy gently, rubbed his back, showed his own facial scar, and talked softly about the boy's family, asking him what he liked to do and play. The mother left the room. The child was quiet, listened to Dr. B., and lay still throughout the anesthesic injection and suturing. His muscles were relaxed and his eyes closed. (This was in spite of the nurse's introjections of "You're such a brave boy, not even crying, and that hurt so much.") The child was told by Dr. B. how to interpret the various sensations (eg, "This will feel kind of funny and numb, but then it won't bother you at all").

The procedure was accomplished quickly, the sutures were clean, and the child was still, quiet, not traumatized, not having to be held down as the nurse had anticipated. Dr. B. was also relaxed and was able to work quickly. Although the nurse gave all the credit for his calm demeanor to the boy, the boy's father was very free with his praise and admiration for Dr. B. Dr. B. commented on his conscious use of hypnotic techniques, which enabled him to gain the boy's attention, empathize with the problem, induce relaxation, prepare the child with interpretations of sensations that were nontraumatic and not painful, and strengthen the boy's ego with praise.

Example 2: Dr. A. and a Veterans Administration Patient. After four painful, resistant, and unsuccessful attempts by Rheumatology Resident X to aspirate a patient's distal interphalangeal joint, Dr. A. entered the room, talked with the patient about his hobbies, and used guided imagery to induce a dissociation from the procedure and increase the patient's tolerance of pain. There was no mention of either hypnosis or relaxation; however, the patient relaxed and allowed the tap to proceed without complaint and without apparent discomfort. Feedback to Dr. A. arrived later via a medical student who overheard Resident X say, "I don't know what she did, but it was amazing."

Example 3: Dr. K. and a Cancer Patient. Dr. K. presented her plan of using hypnosis as a mechanism to teach a somewhat disoriented elderly patient with cancer how to have a better chance of recovery from surgery which could possibly extend her life. The patient was considered at high risk due to her heart condition as well as her advanced cancer and age. Dr. K. was concerned

about the patient's preoperative anxiety and postoperative recovery. Dr. K. had two 15-minute sessions daily for two days with the patient, stressing relaxation, suggestion of recovery, ambulation, appetite, and ability to cough and eliminate. Although initially resistant to relaxation, the patient by her second session was exhibiting eye closure and muscle relaxation, and in fact drifted off to sleep after the sessions with Dr. K.

This potentially high-risk patient made a very speedy and uncomplicated recovery, ambulated on Day 2, ate heartily, and felt little postoperative discomfort. The patient dismissed Dr. K.'s postoperative attempts at reinduction of relaxation, saying, "I don't need that anymore."

The above case histories demonstrate some of the ways family practice residents were able to use hypnosis with their patients during or after their beginning seminar experience. Obviously, not all instances were so successful, and residents also reported their failures. However, in the seminar or in private consultation they rethought strategy, and often were able to go back and approach the patient differently and better. Their mistakes, once admitted and talked about, provided much learning material. When a "failure" has been experienced the motivation to do better is strong if the atmosphere is supportive and provides follow-up.

Comment

Hypnotic techniques as described by Erickson et al[12] are particularly useful in teaching the young family physician about the potency of the spoken word and the physician-patient relationship. Since the nature of the tool is sometimes threatening, it is suggested that the course be offered as an elective for those interested in pursuing their own potential as therapeutic communicators. Often trainees become aware of their own inter- and intra-personal conflicts, especially concerning their therapeutic potential, power, and control. These issues were discussed by the residents as they arose. In all cases there must be a skillful and well-trained practitioner, whether psychologist, psychiatrist, or physician, on hand for backup, reassurance, and encouragement.

The seminar itself was used by the residents as a place to relax, experience trance, and release some of the responsibility for others that they carried all day. Each trainee wanted to experience some different version of trance (eg, to reduce anxiety on a particularly stressful rotation, to cure warts, to tolerate dentistry more easily, or simply to rest a while). The trainees reported sleeping particularly well on the nights after the seminar and feeling comfortable and alert the next morning (though specific suggestions were not given). In practice sessions, residents often worked with a colleague on some very immediate personal issues, such as headache or anxiety. The residents were able subjects, even though they were used to being in cognitive-conscious-affective control. They found hypnosis a safe method of trusting themselves to a different form of control and exploring the realms of their own minds.

Repeatedly, residents recognized in the study of hypnosis pieces of what they already knew. Hypnotic technique was not, by and large, a totally foreign skill. They became more conscious of the significance of their communication with patients and of the suggestions they already used. Training in advanced therapeutic communication gives the physician fluency with a powerful therapeutic tool. It may have impact on prescribing procedures, length of treatment, diagnosis, and general physician-patient relationship skills.

Studies comparing the practices of physicians who use hypnosis and those who do not, and studies evaluating the efficacy of hypnosis as a treatment modality in the family medicine setting are needed.

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