Influence or Ignorance: An Analysis of the influence of the Hypnotherapy National Occupational Standards on Hypnosis and Hypnotherapy Teaching and Learning, and Professionalism in the UK.

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A thesis submitted in partial fulfilment of the requirements of the University of Greenwich for the degree of Doctor of Education

March 2013

DECLARATION

I certify that this work has not been accepted in substance for any degree, and is not concurrently submitted for any degree other than the Doctorate in Education (EdD) being studied at the University of Greenwich. I also declare that this work is the result of my own investigations, except where otherwise identified by references and that I have not plagiarised the work of others.

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ACKNOWLEDGEMENTS

It is with sincere appreciation that I offer my thanks to the staff at the University of Greenwich for their teaching, support and guidance throughout the time of this research. In particular, the inspiration from Neil, Francia, Bill, Anneyce and Shirley.

My heartfelt thanks go to my friends, including Mike Griffiths, for teaching me how to navigate the world of statistics, together with Joe, Simon, Cherie, George, Ildiko and Cherry for their unwavering support!

A special acknowledgement also goes to all those in the hypnosis and hypnotherapy profession, both in the UK and internationally, for their support and contributions during this project.

Finally, I would like to recognise the writings of another teacher, whose work reminds me just how much our words can achieve.

> *"…there has been implanted in us the power to persuade each other, and to make clear to each other whatever we desire, not only have we escaped the life of wild beasts, but we have come together and founded cities, and made laws, and invented arts; and generally speaking, there is no institution devised by man, which the power of speech has not helped us to establish…."*
>
> Isocrates 'The Antidosis'

ABSTRACT

This thesis analyses the influence of the Hypnotherapy National Occupational Standards (H.NOS) on teaching and learning, and professionalism, amongst four groups: hypnosis and hypnotherapy practitioners, researchers, educators and professional organisations.

H.NOS describe effective performance of a role, in terms of the knowledge, understanding and actions. The hypnotherapy profession has recently encountered voluntary regulation with the Complementary and Natural Healthcare Council. Practitioners whose training meets H.NOS are eligible for registration. In response to government initiatives, there is a progression towards professionalism of hypnotherapy, yet wide-spread review of the literature considered the lack of agreed definitions for hypnotherapy and hypnosis, despite a long history and diverse applications. There is little current research investigating any potential influence of the H.NOS, despite implications for current and future practice.

Online quantitative questionnaires completed over a nine-month period assessed awareness of H.NOS and the consultation process, together with their influence on teaching and learning, professional bodies, competence and professionalism. Developed for this study and a unique contribution, the T.A.P. model (Thought, Action, Professionalism), was employed in the questionnaires, to enable respondents to classify their past training in relation to the model, where the H.NOS fits into the model, and where qualifications for practitioners and researchers would be located.

Exploration and inferential analysis with chi-square tests and textual analysis of questionnaire comment boxes, indicated positive outcomes for both research questions regarding the influence of the H.NOS on teaching and learning, and the influence of H.NOS on professionalism.

Original contributions to knowledge and practice comprise the T.A.P. model; the review of a diverse range of literature, and the unique survey and resulting data analysis, together with a range of planned and potential disseminations. Future directions for research include greater research following raising of H.NOS awareness, together with deeper exploration of the potential of the T.A.P. model and surveying practitioners about engagement in research. Recommendations are for an increase in awareness of H.NOS, more access for practitioners to research, and for an externally verified Hypnotherapy National Vocational Qualification for all using hypnosis, undertaken prior to specialisation.

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LIST OF ABBREVIATIONS

AMA	American Medical Association
ASCH	American Society of Clinical Hypnosis
BACP	British Association of Counselling and Psychotherapy
BMA	British Medical Association
BSCAH	British Society of Clinical and Academic Hypnosis
BSCH	British Society of Clinical Hypnosis
CAM	Complementary and alternative medicine
CBT	Cognitive Behaviour Therapy
CNHC	Complementary and Natural Healthcare Council
CPD	Continuing Professional Development
DVD	Digital Video Disc
DoH	Department of Health
ED	Educator (training organisation/ provider)
EJCH	European Journal of Clinical Hypnosis
FIH	Prince's Trust Foundation for Integrated Health
FRC	Federal Regulatory Council
FWG	Federal Working Group
GDC	General Dental Council
GHR	General Hypnotherapy Register
GHSC	General Hypnotherapy Standards Council
GMC	General Medical Council
GRCCT	General Regulatory Council for Complementary Therapies
HEA	Higher Education Academy
HJWD	Hypnosis Joint Working Group
HRF	Hypnotherapy Regulatory Forum
H.NOS	Hypnotherapy National Occupational Standards
HRF	Hypnotherapy Regulatory Forum
HPC	Health Professions Council
HCPC	Health and Care Professions Council
IAAPT	International Academy of Alternative Psychology and Therapy
IBS	Irritable Bowel Syndrome
IFL	Institute for Learning

IIQ	Investing in Quality
LCCH	London College of Clinical Hypnosis
NGH	National Guild of Hypnotists
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NLP	Neuro-Linguistic Programming
NMC	Nursing and Midwifery Council
NQF	National Qualifications Framework
NVQ	National Vocational Qualification
NOS	National Occupational Standards
ONS	Office for National Statistics
PAP	Practice Advisory Panel
PB	Professional Body
PCS	Professional Competence Standards
PSB	Profession Specific Board
PTLLS	Preparing to Teach in the Life-Long Learning Sector
QCF	Qualifications and Curriculum Framework
RCN	Royal College of Nursing
SATC	Science and Technology Committee
SOC	Standard Occupational Classifications
SPSS	Statistical Package for Social Sciences
SVQ	Scottish Vocational Qualification
T.A.P.	Thought, action, professionalism (model)
UKCES	United Kingdom Commission for Employment and Skills
UKCHO	United Kingdom Confederation of Hypnotherapy Organisations
UKCP	United Kingdom Council for Psychotherapy
VSR	Voluntary Self-Regulation
WGHR	Working Group for Hypnotherapy Regulation

1. INTRODUCTION

1.1 Introduction

This thesis analyses the influence of the Hypnotherapy National Occupational Standards (H.NOS) upon hypnotherapy teaching, learning and professionalism in the UK. It determines what influence the H.NOS have had upon hypnosis and hypnotherapy teaching and learning from the perspective of four areas within the field: training organisations, professional bodies, practitioners and researchers using hypnosis and hypnotherapy. Data were sought relating to awareness, teaching and learning, competence and professionalism, using online questionnaires. This study ~~is~~ is considered important as it contributes to the evidence base of an under researched field.

'Hypnosis' and 'hypnotherapy' tend to be used interchangeably throughout the literature and it can be observed in Chapter two (Review of Literature) that there are diverse opinions about the definitions of hypnosis and hypnotherapy. A simple working definition of hypnosis is suggested by this study to be '*a concentrated state of focused attention, with increased responsiveness to suggestion, often accompanied by relaxation'*. A broader definition is given by the American Psychological Society *"Hypnosis typically involves an introduction to the procedure during which the subject is told that suggestions for imaginative experiences will be presented. When using hypnosis, one person, (the subject), is guided by another (the hypnotist) to respond to suggestions for changes in subjective experience, alterations in perception, sensation, emotion, thought or behaviour. If the subject responds to hypnotic suggestions, it is generally inferred that hypnosis has been induced. Many believe that hypnotic responses and experiences are characteristic of a hypnotic state. While some think that it is not necessary to use the word "hypnosis" as part of the hypnotic induction, others view it as essential"* (Green et al. 2005). Hypnotherapy, according to the British Society of Clinical Hypnosis (BSCH), is "*...using the state of hypnosis to treat a variety of medical and psychological problems..."* (BSCH, 2013).

This chapter offers an introduction and overview to the research conducted. It explores the background and journey to formulate the aims and objectives of the study, the

professional context and how this study demonstrates originality. Further chapters explore the literature (chapter two) the T.A.P. model assessment and planning tool (chapter three), and the methodology (chapter four), before analysing (chapter five) and discussing the data and findings (chapter six), which lead to the final conclusions and recommendations (chapter seven).

1.2 Background

The use of hypnosis, for therapeutic purposes, is believed to date back to the times of the Ancient Greeks and Egyptians (Pintar and Lynn, 2008; Waterfield, 2002). The study and use of hypnosis is widely documented through time to the present day. Yet, the field does not always receive credit where it may be due when, as Yapko (2003) indicates, *"...others use hypnosis, and then call it something else..."* (although, precisely what, Yapko does not specify). Throughout this thesis, the words 'hypnosis' and 'hypnotherapy' will be observed. 'Hypnosis' can be considered to refer to the state of hypnosis and its associated phenomena. Thus, a hypnotist will work with creating, maintaining, and working within this state in an individual or group.

'Hypnotherapy' can be considered the addition of therapeutic approaches to hypnosis. A potential confusion can arise, as some therapists use 'clinical hypnotist' as a title (the use of hypnosis and therapy for clinical purposes) and this can be shortened to hypnotist. However, throughout the literature, from historical perspectives to the present day, the two words appear to be used interchangeably. Wherever an individual in the literature has used one or the other word specifically this has been followed in the discussion.

The history and therapeutic approaches are widely documented in the literature, and contemporary research explores direct and indirect use of hypnosis and hypnotherapy. However, little is specifically documented about how hypnosis and hypnotherapy is taught and learned, nor whether such teaching and learning contributes towards professionalism. At the time of writing (March 2013), a search on Amazon (UK), one of the largest booksellers in the UK, found no books available on the actual teaching of hypnosis or hypnotherapy, although many hypnosis and hypnotherapy textbooks are available.

The literature that explores the history of hypnosis (Pintar and Lynn, 2008) appears to indicate that hypnosis education was traditionally passed on from one individual to another, or others, often by demonstration and discussion. For example, Dr James Braid, who in 1843 was so taken by such a demonstration (at the time called 'Mesmerism'), that he went on to widely use it and is credited with the renaming from 'Mesmerism' to 'hypnotism'.

The British Medical Association (BMA) has recognised hypnosis as a therapeutic modality (Brookhouse, 1999) since 1954. Yet, to the present day, it has a very minor role in conventional medicine within the NHS, although some use is made of independent practitioners and it is the independent or 'lay practitioner' field that has grown in recent times.

Notably from the 1970s, hypnotherapy training schools have developed in the UK. These schools have been predominantly private schools, such as the London College of Clinical Hypnosis (LCCH) who teach lay and medical practitioners. Some formalised training of medical and dental practitioners was provided as early as the 1950s and 1960s leading to a professional dental and medical body that, following several name changes, is today the British Society of Clinical and Academic Hypnosis (BSCAH). These provide in-house training of three weekends, although a degree programme (since ceased) was later created exclusively for psychological, dental and medical professionals, which led to a higher category of membership. Over time, lay practitioner and medical practitioner hypnotherapy training has developed and evolved without a widely agreed or defined syllabus, and with courses ranging from those with self-accreditation by the school itself, to accreditation by professional associations and bodies. More recently, the government initiative of occupational standards led to the development of National Occupational Standards for Hypnotherapy (H.NOS). In 1998 the UK Confederation of Hypnotherapy Organisations (UKCHO) was formed. UKCHO was later to play a significant role alongside Skills for Health, in the development of H.NOS.

Skills for Health, an independent organisation, are the Sector Skills Council for Health. They were tasked, by the Sector Skills Development Agency, now, from 1st April 2008 the UK Commission for Employment and Skills, with co-ordinating a range of National

Occupational Standards (NOS) in the health sector. The NOS were designed to indicate measurable performance outcomes for specific occupations. They were developed by relevant stakeholders and specify competence standards for skills, knowledge and understanding. The NOS define the competencies for National Vocational Qualifications (NVQs) and Scottish Vocational Qualifications (SVQ), which are work-based awards, unit based, achieved through a combination of training and assessment. It can be noted that at the present time there is no NVQ for hypnotherapy. The H.NOS do form the basis of some independently designed 'Hypnotherapy Practitioner' level 4 courses verified by the NCFE (their name, not an abbreviation) as meeting their 'Investing in Quality' (IIQ) standards. However, these courses are not nationally recognised in the same way as NVQs, they are not listed on the NCFE website, nor the Register of Regulated Qualifications in the same way as, for example, 500/6328/5 level 3 award in Counselling Skills and Theory (QCF), or 600/0727/8 NCFE level 3 Diploma in Counselling Skills (QCF). Thus, it would appear that at present there are no nationally recognised vocational courses.

A preliminary exploration of a wide range of training available to medical and lay therapists, found a broad variance in syllabus, entry criteria, duration and type of training and often the lack of validation by Universities. However, as hypnosis is something induced by the subject and not the hypnotist (Alman and Lambrou, 1992), we can consider whether there is actually a need for standards and regulation of the practice of hypnosis. Opinion is divided as many medical, dental and psychological practitioners indicate only they should be able to practice, whilst others, the lay therapists mainly, suggest it should be open to a wide range of practitioners. Brookhouse (2006) suggests that this issue was part of the attempt in 1980 to strengthen the powers and scope of the 1952 Hypnotism Act that presently only focuses on hypnosis for entertainment purposes, although this attempt was eventually unsuccessful. This lack of collective direction can be confusing for the public, not knowing the merits or skill level of the relevant training, or which type of 'professional' to visit, whether medical or lay-practitioner. However, the voluntary regulatory body (CNHC) could be seen to offer some protection to the public, ensuring that those registered have been approved by their verifying organisations (hypnotherapy professional bodies) as having received training that, as a minimum, meets the H.NOS. It can be questioned though

whether the move towards regulation adds to the perception of professionalism of hypnotherapy in the eyes of the public or the practitioners.

From a professional background perspective, now more perhaps than any other time in hypnosis history, with the voluntary regulatory body (CNHC) supported by the government and the NHS, and the moves towards integrative medicine, there is a real opportunity for hypnotherapists to be regarded as professionals in the health care arena. The H.NOS may offer those within and joining the profession some guidance as to the minimum standards for skills and knowledge. However, whilst students and practitioners' training may have met the standards required by the H.NOS, it is, as yet, unknown whether they have anything above a minimal knowledge of the H.NOS, or the extent to which they have engaged with the standards. It can be questioned whether, from a learning perspective, students select their training provider based upon whether the training meets H.NOS, or whether other factors (beyond the scope of this research), such as price, location, duration and content are, to them, more relevant. It can also be questioned to what extent these training providers recognise the H.NOS and whether and how they have influenced the provision of training. Furthermore, an exploration can be made, of the views of the training providers as to the influence, if any, of any changes to meet the H.NOS, has had upon the professionalism implied by the course. By their mere existence, it could be questioned whether the H.NOS positively influence hypnosis teaching and learning from a professionalism perspective (Meltzoff, 2010). However, it is suggested that any 'official' standards, whether voluntary or statutory, add to the overall perception of professionalism.

Underpinning this research is a consideration of the theoretical perspectives of professionalism, in terms of an ideology and as a control mechanism. Foucault's concepts of legitimacy (1979), and systems of control (1973, 1980) of autonomous subjects exercising appropriate conduct, including self- regulation and training of the self by one self (Foucault, 2000) is considered with the associated potential connections with H.NOS and voluntary regulation. This also has close implications for the developments with CAM regulation in recent years, from the White Paper for CAM regulation (House of Lords. Science and Technology Committee, 2000), through to the most recent Hypnotherapy Core Curriculum.

Allen (Fonagy, 2010) would suggest that the systemisation of skills and knowledge underpins the psychology therapies professions, yet is part of a 'coming of age' of a craft, which has evolved through social interaction and tacit knowledge. Allen further considers modern professions are attempting to make explicit what has long been implicit.

Budd and Mills (2000b) propose that regulation improves professional status and respect. Furthermore, the CAM regulation White Paper suggests that regulation has an influence on healthcare professionalism (House of Lords. Science and Technology Committee, 2000, s.5.1). This is supported by evidence provided by Ms Julie Stone, in the White Paper, (section 5.22) who suggested that the current professionalization taking place within CAM was to be encouraged.

Thus, it can be seen that there are social, intellectual, professional and research aspects, together with professionalism aspects, to the research questions relating to the extent of influence of the H.NOS upon teaching, learning and professionalism.

1.3 Professional significance

The question of the influence of the H.NOS is of fundamental importance to the hypnotherapy profession and the hypnotherapists within as these are designed to be the guide for what minimum skills and knowledge are required to be deemed a hypnotherapist. If there is a lack of awareness, or recognition of these standards, then it could be questioned whether they are of any value to the public or the profession. The focuses of this study consider the influence on hypnotherapists, researchers using hypnosis, educators (hypnotherapy training schools) and hypnotherapy professional bodies. The professional significance of influence in each of these areas is of importance to a collective of the profession.

For hypnotherapists, the H.NOS may be considered their 'minimum standards' to be attained to be considered a practitioner. Although, as this study data will indicate, not all researchers may be trained to the H.NOS standards, they conduct research that informs the profession and wider audience. Thus, it would seem reasonable that those

informing the profession apply hypnosis from an informed foundation, such as having training which meets H.NOS and the core curriculum as a minimum.

For educators, whatever the size of their training school, providing appropriate training has relevance to both the professional bodies of which they are members or receive accreditation, and to their students who will wish to become members of the professional bodies. Where educators might pay little attention to the H.NOS, the potential therapists may find their skills and knowledge lacking in depth or breadth required by the professional bodies and furthermore then be unable to register with the CNHC.

For the professional bodies, a lack of engagement with the H.NOS can influence both their ability to be a verifying body for the CNHC and their ability to attract quality educators and their hypnotherapy training schools who wish to ensure their students as graduate members will be appropriately supported.

It is to be recognised that the CNHC is a voluntary regulation body and that the H.NOS have no legal standing in terms of professional conduct. There is no legislative requirement for practitioners, researchers, educators or other professional bodies to observe H.NOS, nor be associated with the CNHC. However, the CNHC does have the support of the Department of Health who indicate that where complementary and alternative therapies are regulated by the CNHC that the public should go these appropriately qualified members. Thus, it would seem in therapists' professional and business interests to be members.

1.4 Focus of previous studies

Hypnotherapy research topics tend to concentrate interest and activity towards therapeutic intervention possibilities. These include hypnosis and hypnotherapy influence in adjusting attitudes, beliefs, perceptions and behaviours associated with the treatment and management of a broad array of psychological and medical conditions (DuBreuil and Spanos, 1993; Chaves, 1993, 1997; Pinnell and Covino, 2000) and its application for a broad variety of individual conditions including anxiety (Mellinger, 2010), cancer (Néron and Stephenson, 2007); depression and depression relapse

prevention (Alladin, 2006, 2010; Yapko, 2003); habit control (Green, 2010); headaches and migraines (Hammond, 2007); Irritable Bowel Syndrome (Palsson *et al.*,, 2002); pain (Patterson, 2010); psychosomatic disorders (Flammer and Alladin, 2007); post-traumatic stress disorder (Spiegel, 2010); and sleep disorders (Graci and Hardie, 2007). In addition to a focus on conditions and approaches relating to the 'disease model' (Green et al., 2002) there is also a growing body of evidence relating to enhancement of performance, such as in acting, business and education environments, and in wellbeing development. One of the most notably expanding areas of such development is in sport enhancement (The Centre for Sports Hypnosis, 2013) and recognising the use of hypnosis in sport (Barker *et.al*, 2013).

However, there appears to be little research into the influences upon the hypnotherapy profession. At the time of writing this chapter (October 2012) despite wide-ranging printed and electronic searches, supported by informal discussions with those in relevant roles, such as trainers and teachers, practitioners, researchers and managers of professional bodies, there appeared no published research related to the influence of the H.NOS.

1.5 The journey

The background section has explored the journey of hypnosis and hypnotherapy to the present date and raised questions about the influence of the H.NOS upon several aspects of the hypnosis and hypnotherapy field, together with considering the relevance for this research. The deeper history of teaching and learning of hypnosis, professionalism, and the H.NOS are explored in more depth in the Review of Literature (chapter two). As can be observed in the subsequent section, the aims and objectives of this study have evolved during the development of this study and this has formed part of my journey to this point.

At the time of writing this thesis, I am a trained, qualified and experienced clinical hypnotherapist, Board Certified hypnotist, Certified Instructor and hold several post-graduate qualifications in hypnosis, hypnotherapy and psychology. I have lectured on hypnosis, hypnotherapy and hypnosis training in the UK and internationally, including the National Guild of Hypnotists World Education Conference in Boston in 2009, 2010

and 2012 (also scheduled for 2013), and the University of East London Learning and Teaching Conference in 2010. I have also talked to staff at Harvard University and taught students at Eton College. Furthermore, I have taught sport hypnosis at a London University to sports coaches, and presently teach hypnotherapy in both Further and Higher Education. Yet hypnosis teaching and learning was not the initial focus on my Doctorate of Education studies.

With a career as a Chartered Health and Safety Practitioner, leading on health and safety training for my organisation (a London University), my doctoral research during the taught phase considered health and safety training and my thesis was initially going to focus on Kholberg's moral development and performance during health and safety training. However, despite my employers being a University, they did not support research, offering a reason that I was already well qualified to conduct my role and as a member of 'support staff' I was not required to conduct research. As my employment contract prohibited work elsewhere (and providing the training to subsequently research counted as work), it was necessary to find a new focus for my research. The subsequent development of this delayed my research progression by almost two years.

Around the time of needing to find a new field to research, I was involved in further training to become a clinical hypnotist, and, fascinated by the subject, I undertook a vast range of courses including: online, DVD, short duration (one to five day) training, residential training, and an immense range of 'How To' books. This was in addition to a formal, three-year programme, with attendance one weekend each month. What I found was a substantial difference in how hypnosis was taught and how hypnotists and hypnotherapists were perceived and perceived themselves and their extent of training. On hypnosis and hypnotherapy training courses, educators ranged from those who had little teaching or training experience, or little professional experience, through to those with many years experience, and the knowledge and skills to communicate the training material to students. Within this is are debates for another time of whether students are being 'trained' or 'taught' and whether a practitioner is regarded as 'a professional'.

Attendance on this range of courses, particularly having attended the taught two years of the EdD programme and having taught in a University environment, demonstrated to me the widely varied perceptions of how to teach hypnosis and what was being taught

and for what purpose. It led to many questions, such as whether it was 'vocational' or 'academic' learning; if vocational, whether vocational training led to professionalism; how to define a professional and whether the definition was dependent on the way one acts or whether it was dependent on engagement in a predefined job-specific role or the perception of others dependent on the extent and depth of training. So many questions arose, yet I could find few hypnosis-specific answers in the literature and contemporary or traditional research. Furthermore, on reflection, not mentioned during any of my training, nor in subsequent Continuous Professional Development (CPD) training, were the proposed and subsequently accepted H.NOS. These standards have been revised several times since their launch in 2002, and are now, as from late 2012, supported by a Core Curriculum.

1.6 Aims and objectives: The research questions

The initial development of the research question explored H.NOS influence on hypnotherapy training. With further reading and development of understanding, the focus moved to asking how the H.NOS influence hypnotherapy training in the unregulated hypnosis industry, with five sub-questions asking about: their influence in current training provision and selection; whether they are considered the standard for training by professional bodies; their influence upon qualified hypnosis and hypnotherapy practitioners and researchers; and any potential influence on professionalism within hypnosis and hypnotherapy.

However, over time, with deeper reading, integration and understanding of the issues involved, these research questions have developed, consolidated and solidified into their final format. The over-arching research question was 'What influence have the H.NOS had upon hypnosis and hypnotherapy teaching and learning, and professionalism in the UK?

This was sub-divided into two research questions:

1. What influence have the H.NOS had upon hypnosis and hypnotherapy teaching and learning?
2. What influence have the H.NOS had upon hypnosis and hypnotherapy professionalism?

Four specific sectors of the hypnosis and hypnotherapy sector were identified as targets for these research questions: practitioners, researchers, educators (training schools) and professional bodies.

1.7 Professional context

Anticipated outcomes

It was envisaged that the evidence emanating from this research would indicate the influence of the NOS amongst the four groups: practitioners, researchers, educators, and professional bodies. Furthermore, whilst there is some literature regarding professionalism and complementary and alternative medicine (CAM) this rarely considers hypnosis and hypnotherapy. This work is considered the first to explore the influence of the H.NOS, as well as being a large-scale examination of perceptions of teaching and learning, and of professionalism.

Anticipated contribution to knowledge and dissemination of research

This research is believed to be the first survey of the influence of the H.NOS. It is hoped that the outcomes of this research will offer the hypnotherapy and wider professions a clear indication of the influence of the H.NOS on hypnosis and hypnotherapy teaching and learning and on professionalism.

The research outcomes will be widely disseminated within the hypnosis and hypnotherapy world, to the professional bodies of which I am a member, as well as to appropriate UK and international hypnosis and hypnotherapy journals such as the *European Journal of Clinical Hypnosis* and the *Contemporary Hypnosis and Integrated Medicine Journal*, as well as the broader education and psychology journals. Furthermore, a conference abstract will be submitted, for consideration, to the European Society of Hypnosis annual conference.

There have already been expressions of interest from the regulatory body, professional bodies and the media. It is also anticipated that the research will be included in a book about hypnosis and hypnotherapy teaching and learning which will include the research outcomes and adaptations of some of the work from the taught elements of the Doctorate of Education programme.

Anticipated influence on professional practice

It is envisaged that the emerging knowledge of this work will indicate the current approaches of training providers and their views on the H.NOS. This may have an influence upon any voluntary or statutory regulation, together with the future design of courses and possible definition of standards by professional bodies. It is anticipated that it will inform any development of a vocational training programme (such as a hypnotherapy NVQ). It will also support the evidence-based writing of an educational module or short course in hypnosis for Universities. Furthermore, it will inform the profession as a whole on aspects of training and professionalism.

Anticipated future research

It is planned that future research into influences upon hypnosis teaching, learning and professionalism will be developed beyond the scope of this study to further develop the body of knowledge in this field and to provide supporting evidence for a book on teaching and learning for the professional hypnotist and educators. This may include research into any changes in perception following any awareness-raising of the H.NOS and into the potential influence of any development of a Hypnotherapy National Vocational Qualification. There is also potential for an impact assessment of the H.NOS.

Both this research and future developments will add to and inform my present teaching in further and higher education. Moreover, it is anticipated that the T.A.P. (Thought, Action, Professionalism) model, created for this research (see 1.8 below), will be further evaluated as a benchmarking tool.

1.8 Originality

It is proposed that this study contributes to the evidence base of the fields of hypnosis and hypnosis teaching, learning and professionalism, and in the field of the NOS, both in general therapy and specifically related to hypnotherapy. Widespread printed and electronic searches have indicated there is currently a lack of research of this nature.

Furthermore, in the absence of a suitable model in existence, an original model, the T.A.P. (Thought, action, professionalism) model was devised (see Review of Literature

chapter), following extensive literature research, to enable study participants to classify where they consider themselves to sit from a professionalism perspective. This model was incorporated into the online questionnaires.

1.9 Introduction summary

This introductory chapter has presented the rationale for the study to analyse the influence of H.NOS upon hypnotherapy teaching, learning and professionalism in the UK. The background to hypnotherapy teaching, learning and professionalism is further explored in the next chapter. The journey to the formulation of the aims and objectives informed the hypotheses and research questions will continue to inform the work in subsequent chapters, influencing the Review of Literature (chapter two), the T.A.P. model assessment and planning tool (chapter three), and Methodology (chapter four), the Data Analysis (chapter five) and Discussion (chapter six) of the research data, through to the final Conclusions and Recommendations (chapter seven).

2. REVIEW OF LITERATURE

2.1 Introduction

The aim of this study is to explore the influence of the hypnotherapy National Occupational Standards on teaching and learning, and on professionalism. The Introduction (chapter one) outlines the factors leading to this research, the background, and the journey taken, together with the professional significance, context, influence and originality, and the aims and objectives of the study. Following this Review of Literature, is a chapter (three) on the T.A.P. Thought, Action Professionalism model, an original contribution of this study, which provides a tool to assess and compare training, and use in planning for future development. The Methodology (chapter four) will discuss the relevant aspects of methodology and research design, with subsequent chapters on Data Analysis (chapter five), Discussion (chapter six) and the final Conclusions and Recommendations (chapter seven).

This chapter commences with clarification of the question 'What is hypnosis?' considering the definitions and perspectives, how the history of hypnosis has contributed to the hypnotherapy profession and exploring key debates in hypnotherapy. It then moves on to examine how and what hypnosis research has been conducted and the translation of theory to practice, considering the scope of hypnotherapy use, the perceived dangers and whether indeed, hypnotherapy is a standalone practice. The profiles of lay and medic hypnotherapists are considered, together with an exploration of the range of individuals who seek hypnotherapy, whilst examining uses including private therapy, within hospital environments, the growing field of sport hypnosis and applications within the military.

This is followed by a review of legislation and government influences, and an exploration of the issues relating to Regulation and the potential implications arising from two relevant White Papers, on CAM and regulation of health professionals. Contributors to the development of the voluntary regulator, the CNHC, together with the responsibilities of the CNHC and the function of the Professional Standards Authority (PSA) and alternative regulators are also explored.

The role and actions of verifying organisations and professional bodies are considered, in addition to the Standards and the National Occupational Standards (NOS), in general, and then specifically related to hypnotherapy (H.NOS). The influence of Skills for Health and the UK Commission for Employment and Skills and are considered prior to discussing the new Core Curriculum for hypnotherapy.

Hypnosis education is discussed, considering the breadth of types of training, and how people teach, together with matters relating to learning, knowledge, and extent of training, as well as the issues about practicing, and continuous professional development, before ending on verifiable training. How this training is measured, compared, assessed and means of benchmarking is reviewed. This leads, finally, into a discussion about professionalism from the theoretical and hypnosis perspectives. These later sections particularly influence the following chapter (three), on the T.A.P. (Thought, Action, Professionalism) model, which was a unique contribution, focusing on thoughts, actions and professionalism.

Included in this chapter will be an exploration and comprehensive critique of the literature, describing the search process, the theoretical literature and the empirical research (Glatthorn, 2005). The advice of Bryman (2001) is heeded, in that we consider the purpose for which the research was originally collected, and that it represents attitudes, opinions and political direction that may be explicit or part of a hidden agenda. Thus, material encountered may not be as objective as it initially appears and uncritical use of such evidence could introduce a bias, thus as hypotheses, assumptions, theories and interpretations are considered and compared, their relevance will be discussed. However, any consideration of the material can create new insights, and no matter how small, new insights can offer valid contributions to a wider field (Burgess et al., 2006).

2.2 Definitions, historical overview and current understanding

The question of what, exactly, specifically, hypnosis and hypnotherapy are, is a matter of historical and contemporary debate and, even today, views are varied, despite advances in scientific analysis of hypnosis processes. The historical contributions are

worthy of consideration as are current understandings including some of the more persistent and prominent debates.

What is hypnosis?

Hypnosis has always been an enigma and it can be said that the more it is subjected to the light of modern empirical scrutiny, the more it eludes definition (Pratt *et al*., 1988:1) as has already been alluded to earlier in this thesis. So much so that Mc Coll (2004) suggests avoiding 'the herd-mind trap' of attempting to define hypnosis and Lesser (1991:35) suggests the answer to that question could be very short or very long. Weitzenhoffer (2000) considers that little has changed about hypnosis since 1948 when he first started gathering data for his first book, it remains a 'vague, ubiquitous subject' (Weitzenhoffer, 2000:597) with a domain which is 'increasingly disorganized, ubiquitous and amorphous' (Weitzenhoffer, 2000:602) and it can be said that the myth change takes a long time (McKenna, 2004) to reflect science or reality. Research conducted by Northcott (1996) compared responses to the statement 'hypnosis can make people tell the truth'. Although only 10.4% of current hypnotists (n=601) surveyed by Northcott believed that statement to be true, this increased in other groups including 18% of psychotherapists (n=869), 47% of pain therapists (n=189), and a worrying 86% of medical and psychology students (n=184) believed the statement to be true. Thus, the dispelling of myths still has some distance to travel. Dispelling myths and defining any psychological therapy, whether hypnosis or otherwise, is a complex process. Fonagy (2010) suggests the difficulty in defining is not due to the reluctance of professionals to accept reductive specifications of their speciality, rather that they work to 'ideal prototypes' with features in common with a specific category against which new instances are compared.

It would seem there are many views about what hypnosis is, often so far from true to be ridiculous, with Tebbetts (1995) suggesting there is nothing supernatural or magical about hypnotism. However, Hewitt (2005) considers most people lack good information and possess a great deal of misinformation about hypnosis. People may not even be aware that they are in and out of hypnosis many times a day, such as when engrossed in a television programme (Davis *et al*., 1995).

For Chase (2007:17) hypnosis is not relaxation, sleep or any derivative, descriptive often associated with the perceptions of hypnosis. Furthermore, he considers that what most people regard as hypnotherapy is usually 'relaxotherapy'. However, Ireland (2010:179) would seem to disagree, as he considers hypnosis is an artificially induced sleep-like state. A formal definition, the CNHC complementary therapy descriptors (CNHC 2012a) consider hypnotherapy to be a skilled communication which is aimed at directing an individual's imagination in a manner which aids the elicitation of change in perceptions, sensations, thoughts, behaviours and feelings.

Where literature sources use a specific 'label' such as 'hypnosis' and 'hypnotherapy' this is carried through to this thesis. However, this may be in contrast to the general definitions used in this thesis for 'hypnosis' as the state of hypnosis and associated phenomena, and for 'hypnotherapy' as the use of therapeutic approaches together with hypnosis and the associated phenomena. It can also be noted that in earlier times, particularly up to the 1960s, the term 'hypnosis' was given to work where therapy was or may have been conducted.

Over two centuries it would seem that hypnosis has been repeatedly discredited, misconceived (Hawkins 2006) and then rehabilitated (Scheflin and Shapiro, 1989). Hypnosis has suffered from bad public relations (Connolly, 2007: 8) and dramatisations such as those of the novel Trilby in which the unscrupulous Svengali seemingly brings a beautiful young girl completely under his hypnotic control (Kahn, 1945:40) does not help build new positive perceptions. At times, it would appear the term 'hypnosis' still conjures up visions of evil and manipulation (Hartman, 2000). For example, Derren Brown, the popular entertainer and hypnotist (2006:124) recounts having borrowed books from the library and those 'evil alternative books' (hypnosis books) and practiced on friends. Perhaps these books were more likely to be Ellis's 'Black Book of Hypnotic Mind Control' (Ellis, 2006) than Byng's children's story book 'Molly Moon's Incredible Book of Hypnotism' (Byng, 2002). Perhaps also, if hypnosis had not been perceived as 'evil' or 'alternative' they might have been less appealing to the younger Derren Brown. It is considered by some that the literature on hypnosis is a fascinating amalgam of anecdotal assertions, mystical speculations and extremely astute clinical observations (Spiegel and Spiegel, 1978).

In recent years though, Voit and Delaney (2004) suggest the popular and professional perception of hypnosis seems to have matured beyond myth and magic to one of genuine interest and broader acceptance, with such gains having been achieved despite perpetuation of long-standing and unfounded fears and misconceptions by films and media. However, Tebbetts (1990:86) considers many people prefer the mysterious to the scientific, having faith in things they do not understand and preferring to trust the unknown, rather than established facts. Indeed, a survey by Johnson and Hauck (1999) found most people had a positive view of the therapeutic benefits of hypnosis. Research into the efficacy of hypnosis is attracting greater attention, with Flammer and Bongartz (2003) locating a substantial 444 studies for their meta-analysis on the efficacy of hypnosis. Perhaps a factor for this is that, according to Ledochowski (2003), hypnosis is a fascinating field that many people wish to understand. Moreover, hypnosis can be considered both an art and a science, where natural flair, passion and charisma can bring the material alive. Unlike many other sciences, such as mathematics where the personality of mathematician will have little influence on a factual outcome, with hypnosis, positive qualities of an individual can have a demonstrable effect on an outcome. Also unlike the sciences, some key terms such as 'hypnosis', 'hypnotism' and 'hypnotherapy' are used differently within the sector, for often the same action, effect or phenomena. This inconsistency can lead to considerable confusion for those unaware of this and attempting to seek accurate and consistent definitions.

Hypnotherapy appears to be rapidly becoming more accepted as complementary to traditional medical therapies (Hambleton 2002), with medical practitioners able to recommend it to their patients in some cases (such as for Irritable Bowel Syndrome). Fewell and Mackrodt (2005) found 5% of those who responded to their survey seeking information about awareness and practice of Complementary and Alternative Medicine (CAM) by staff in NHS settings, were complementary therapy trained. This is a notable indicator of how widespread CAM is becoming. Korn and Johnson (2005) do suggest that medical care is undergoing a revolution, and a new paradigm of health care must be devised which allows for the mind-body dualism. This is also highly relevant, perhaps indicating a shift in mindset to recognise the potential of talking therapies, such as hypnotherapy. Mills (2001) consider that complementary therapies, of which hypnotherapy is one, have been more widely used over the past two decades, with a survey of 2853 adults indicating 1% has used hypnosis in the past year (Thomas *et al.*,

2001). Hambleton (2002) goes on to say the nature of hypnosis is enigmatic and poorly understood.

It may be that this lack of understanding is what may be holding back hypnosis from the widest possible recognition. Hale (1998:10) asks what does the future hold for complementary medicine? It seems likely that public demand will continue to grow, with a shift towards a more holistic approach. Furthermore, Hale suggests there will be increasing co-operation between orthodox and complementary practitioners. In the UK and US, more and more physicians are referring patients to complementary medicine and some medical insurance companies are funding more complementary treatments. Yet, it must be questioned, whether a therapeutic approach that has yet to offer a comprehensive and broadly agreed definition, will ever truly reach its potential.

The 'bread and butter applications for hypnosis' as Gafner (2006:5) refers to the traditional uses of hypnotherapy, such as for anxiety reduction and behavioural change, are perhaps easier to classify and bring within a regulatory concept than the more intangible elements, such as experienced insight. Thus, it will be of interest to consider whether adoption of the National Occupational Standards (NOS) for Hypnotherapy is common practice amongst practitioners, researchers, training organisations and professional bodies and whether there are any connections between the H.NOS and concepts of professionalism.

A precise definition of exactly 'what hypnosis is' has always been and is currently widely debated. From time immemorial, Mankind, under one name or another, has been fascinated by hypnotism (McGill, 2004a, 2004b) and it could be difficult to find a more controversial and generally misunderstood, yet so widely applied, subject than hypnotism. Hartland (1975) suggests that throughout its many changes, that hypnosis has always simultaneously aroused more enthusiasm and prejudice than almost any other in the whole field of medicine.

History

It may be wondered whether knowledge and understanding of hypnosis history is at all relevant to understanding what hypnosis is. Gibbons (2001:9) suggests those who do not know history are doomed to repeat it and that nowhere is this more true that in the

history of hypnosis and other forms of trance experiences induced by suggestion. A more positive view may be that we can learn the lessons of history, with many of the theories relevant to the present date, although Kuhn and Russo (1958) suggest golden age of hypnotism to be between the 1880s and 1890s. A summary of the key historical and contemporary theories and developments can be found in Appendix A1, which may be of interest from both teaching and learning and professionalism perspectives.

Hypnosis is skyrocketing as a profession, enjoying more popularity than at any time in history" (Hunter, 1998). Understanding of what hypnosis is and its professional and public perceptions of its professionalism have varied since the earliest of times. Credibility appears to be hard won in every generation and perhaps only in later generations, with the advances of scientific investigation, is it possible to look back and apply scientific explanation to what was then 'known'. For example, Mesmer in his dissertation wrote of the difficulty met with establishing and gaining credibility for 'animal magnetism' (Bloch, 1980) and certainly struggled with public perception of his professionalism, yet mesmerism, as an approach, is still taught in 2012 and a search on YouTube, a popular source of practical and skills related information, will find many demonstrations of it.

Some prominent figures throughout hypnosis history have strived for acceptance of the professionalism in hypnotherapy. Smale (2006:184) suggests Milton Erickson was responsible for taking hypnotherapy from a 'Cinderella' therapy to a respectable and proper occupation. However, there are many anecdotal tales of some 'extreme' and very direct approaches that Erickson is said to have taken. It could be considered that these approaches were accepted due to Erickson's medical status and the perception of medical practitioners during that era. There are some fascinating associations between the modern hypnosis and hypnotherapy and early times. Talk of Asclepios and the ancient physician using deep sleep and stroking patient to reduce pain, perhaps an early version of Mesmeric passes or later 'glove anaesthesia'. Touch has historically had much significance, such as the King's evil, from the time of Edward the Confessor, which assumed the King of England had divine right of healing by touch, reported Charles II healed thousands (Simons *et al*. 2007).

An early form of Psychoneuroimmunology can be seen in the mind-body connection promoted by Paracelsus (1493-1541), also known as Theophrastus Bombastus von Hohenheim (Simons *et al.* 2007) and Greek physician Hippocrates (460-377 BC) referred to as the 'father of medicine' who was aware of interrelationship between body and mind (Hambleton, 2002).

From a physical wellbeing perspective, Rossi and Cheek (1994) suggests that since ancient times, healers have been aware of the effects of works and ideas upon our physical wellbeing. From a cognitive perspective, the power of suggestion also has a long history. Slater (1958:5) considers the principles of thought control have been around for thousands of years in India, Persia, Ancient Egypt, and China, with India and Africa particularly having a long established connection with hypnosis (Ousby, 1979) and being embedded as a cultural phenomenon in many cultures for centuries (Lankton and Lankton, 1983:3). Guyonnaud (2007) looks at primitive societies, especially in Africa, the South Sea Islands and South America, and suggests it is not difficult to come to the conclusion humans have been using hypnosis since prehistoric times. He refers to witch doctors and shamens who have helped cure sickness and injury, who traditionally relied on the power of words to help cure sickness and injury. He also refers to the famous Ebers papyrus in the British Museum revealing in the time of the Pharaohs, a method involving the use of verbal suggestion was used to alleviate or cure pain. Furthermore, Ancient Greek and Roman histories allude to the use of verbal incantation for curative purposes (Guyonnaud, 2007).

The 1700s were particularly prominent in more recent hypnosis history with Mesmerism attracting attention in Europe (Hambleton, 2002). Although, at the time, a Royal Commission by King Louis XVI in 1784 found the cures of Franz Anton Mesmer were explained by the imagination; this can now be accepted as a confirmation of the power of the imagination and the mind-body connection.

There were several prominent figures in the 1800s that have had great influence in the development of hypnosis. James Braid's original work was published in 1843 (Braid, 1994) and explores a wide range in subject responses. Also influential in those times was James Esdaile, renowned for conducting many surgeries in India using mesmerism for pain alleviation (Hambleton, 2002:6) and Dr Joseph Breuer, a Viennese physician

who found problems explored in trance disappeared afterwards. In the late 1800s, hypnosis was starting to be explored by psychologists, researchers and doctors including Charcot, Janet, Liebault, Freud and Bernheim, later credited with bringing the power of suggestion to the hypnosis process (Simons *et al.*, 2007). Around this time, Professor Azan of Bordeaux suggested, in a Report to the Society of Surgeons in Paris, that hypnosis should replace chloroform.

Hypnosis use started to become more known and reported in the early 1920s, with medical circles in the Soviet Union engaging into research and reports of Germany, Central Europe, Scandinavia and elsewhere with hypnosis becoming known as a helpful adjunct to modern medicine (Guyonnaud, 2007:22). Hypnosis is widely reported as having been used in World War I, for pain relief, symptom removal and later for addressing repressed traumatic experiences (Hambleton, 2002:7). One of the most prominent hypnosis researchers of the time, Clark Hull, attributed the development of the field of psychology to providing the hypnosis research with additional experimental methods and devices and this 'despite the very devious and unscientific history of hypnotism' (Hull, 2002:21). Such development continued post World War II, with an increase in the theoretical knowledge of the psychodynamics of hypnosis (Meares, 1972). However, Meares also suggests that many articles on hypnosis in general, in medical journals and in practical hypnosis books seem to be out of touch with the newer theoretical concepts, thus new developments have not necessarily been well disseminated. As hypnotists and hypnotherapists anecdotally seem to find books useful and popular for CPD, this can limit development of expertise and thereby professionalism.

Another prominent researcher of the time was Hilgard, particularly known for his research on hypnotic susceptibility and the theory of neo-dissociation. The Stanford Hypnotic Susceptibility Scales (SHSS) are one of the most commonly used susceptibility measurement scales used in research today.

One of the key figures in the 1970s, was John Hartland, whose technique for 'ego strengthening' has formed a common element of most hypnosis sessions today. It is reported he achieved a 70% success rate with patients, using just ego strengthening (Simons *et al.* 2007). Hartland's textbook, *Hartland's Medical and Dental Hypnosis*,

now in its fourth edition, is a popular textbook (indicated by Amazon listing place) for much clinical hypnosis, in the UK and wider, offering a blend of theories and techniques.

Heap *et al.* (2004:9) suggest the requirement of any theory of hypnosis is that it provides explanation of the phenomena we observe, whether it is the conditioned reflex theory of Pavlov or the Dissociation theory of Pierre Janet and Morton Prince (Teitelbaum, 1980:8). Hartland (1975:121) considers there to be nine principal, traditional theories: Charcot's pathological theory; Physical theory; Modified sleep theory; Conditioned reflex theory; Dissociation theory; Suggestion theory; Role playing theory; Psychoanalytic theory; and Meares' theory of atavistic regression (see Appendix A1).

Whilst other hypnotists in more recent times have attracted media attention, such as Paul McKenna and Derren Brown, the final key figure to be mentioned, is Erickson, perhaps the most celebrated figure in the history of hypnosis. The 1980 International Congress on Ericksonian Approaches to hypnosis and psychotherapy was attended by 2000 clinical psychotherapists alone.

A key figure, effective therapist, renowned teacher and founder of an entire hypnotherapy paradigm, Milton Erickson, MD, is often referred to as the grandfather of hypnotherapy, and, according to Hunter (1998:32) "*forever changed its history*". People with outstanding professional credentials have examined, analysed and written books about his work, with a book about Erickson appearing almost monthly or so it seems (Haley, 1993:9). When Erickson first began publishing in the 1930s hypnosis was, according to Rossi, in a curious position (Rossi, 1980b) with views that hypnosis had played a central role in the early studies of psychopathology and the first efforts at psychopathology, yet hypnosis was regarded, at that time, as nothing more significant than a colourful curiosity in our therapeutic past.

That curiosity certainly would appear to have a voracious appetite as, at time of his death on 25th March 1980, Milton H Erickson was said to have written over 300 professional papers and hypnotised over 30,000 subjects (Short *et al*., 2006).

Prominent debates within the hypnotherapy sector

There are many debated and varied paradigms within hypnotherapy, such as between those who follow a hypno-behavioural path and those who favour a more hypno-analytical or cognitive-hypnotherapeutic route. Across all individual paradigms and perspectives, although to varying degrees of importance, continues the 'state / non-state' debate of whether hypnosis is a different state, or not.

Graham Wagstaff (Kunzendorf *et al.*, 1996:19) perhaps best summarises it, that, according to the established state view, hypnosis is best conceptualised as an altered state of consciousness with various depths, such that the deeper one experiences the hypnosis state the more profoundly hypnotic phenomena will be experienced. In contrast, is the perspective that hypnotic phenomena are more readily explicable in terms of more ordinary psychological impressions, such as attitudes, beliefs, expectancies, compliance, attention, concentration, distraction and relaxation. Whilst the state / non-state debate is of importance to both academics and practitioners, it will only influence training, qualification and practise of therapists if an unbalanced or weighted view is presented. The most significant and far-reaching debate that may influence participants within this study, is that of the 'lay practitioner / medical practitioner' differentiation. There is a clear division between hypnotherapy lay practitioners and medical personnel who also use hypnotherapy as part of their usual work. What complicates this picture slightly is where lay practitioners use hypnotherapy in medical settings (as the author does) and where medical practitioners also take on the role as 'hypnotherapists' and see clients for non-clinical issues such as sports enhancement and exam preparation. In 1995, McKenna *et al.* (1995:78) report there to be around 700-1000 doctors and dentists using hypnosis in Britain and 2000 lay hypnotists. It would seem there are few later surveys of the number of medic and lay hypnotherapists and hypnotists.

It is possible for doctors to refer their patients to a lay hypnotherapist (Wilson and Branch, 2006:253). The General Medical Council (GMC) guidelines also indicate that where doctors refer patients to a CAM practitioner, that 'Good Medical Practice' requires that they are accountable to a statutory regulatory body (House of Lords. Science and Technology Committee, 2000, s.5.72). Should they delegate treatment to a non-statutory regulated practitioner, the GMC indicate the doctor retains overall

responsibility for the care of their patient. It could be argued that for doctors to make informed recommendations and referrals, they need a clear understanding of what the therapy can and cannot achieve. However, not all doctors, nurses and other medical personnel are well informed on matters relating to hypnotherapy or CAM in general.

The British Medical Association (BMA) formally approved the medical use and teaching of hypnosis in 1955 and disapproved of its use by the laity (Cooper and Erickson, 2006) yet many medical schools do not appear to cover it on the curriculum (Jackson, 2003). The BMA recommended that a description of hypnosis and its psychotherapeutic possibilities, limitations and dangers be given to medical undergraduates and instruction its clinical use be given to certain postgraduate trainings. However, Hambleton (2002) reports a study by Scott (1978:13) that of the 32 medical schools and 18 dental schools, only two medical schools provided some limited postgraduate studies. This would appear to be an under-researched area, as any later studies could not be sourced. Whether this is as a result of a lack of interest or lack of awareness is open to debate.

The American Medical Association (AMA) has accepted hypnosis as an adjunct to standard medical care since 1958 and recommends it be taught in medical schools as a medical methodology of significant value, yet Temes (2004:253) reports that many physicians in USA know little about it, if anything at all. Perhaps dentists are better informed, as since 1955 for the Marquette University School of Dentistry and since 1956 for Tufts University School of Dental Medicine there have been formal seminars on hypnosis as part of postgraduate instruction. In 1957 the American Society of Clinical Hypnosis (ASCH) was formed, permitting membership of individuals with doctorate degrees in psychology, dentistry and medicine. However, in the absence of any quantitative studies investigating awareness, it cannot be estimated how many clinicians and medical practitioners are aware of either the history of hypnosis, or its contemporary use and supporting evidence.

The White Paper (House of Lords. Science and Technology Committee, 2000, s.6.79) considers the provision of CAM familiarisation in medical schools is currently too uneven and suggest every medical school ensures medical undergraduates are exposed to a level of CAM familiarisation that enables them to be aware of the choices their

patients might make. Furthermore, in Section 6.80, considering postgraduate familiarisation for doctors, that CAM familiarisation be extended to 'Continuing professional Development' (CPD) programmes as this would capture existing qualified doctors. It is to be desired that the training provided is evidence-based and without bias. This would help to prevent the continuance of many hypnosis myths such as those observed by the psychiatrists Goldberg (2005:129) who he considered, tend to scoff at hypnosis, due mostly to the prejudice incurred during their training and their exposure to hypnosis portrayals in the media.

The White Paper (House of Lords Science and Technology Committee s.6.87) confirms that historically many medical practitioners have delivered CAM alongside conventional medicine, such as the Royal London Homeopathic Hospital. It can be noted that the report stresses that staff are "*all statutorily-registered health professionals with additional training in CAM"*, thus it would appear that staff are registered with their appropriate medical body, which is a statutory requirement for their primary field (such as dentistry). However, the White Paper does not mention whether staff that have additional training in CAM are also registered with the appropriate voluntary regulatory body for CAM, such as the CNHC.

The General Medical Council (GMC), the regulatory body for doctors, code of ethics covers the use of CAM therapies, as mentioned in the Medical Act 1983, although the GMC stress, in their evidence to the House of Lords Science and Technology Committee a desire for practitioners to work within their competence and be appropriately qualified. The British Medical Association (BMA) in a report *New Approaches to Good Practice* indicate medical practitioners wishing to practise CAM should undertake training by an 'appropriate' (unspecified) regulatory body, yet such training is not yet available.

For nurses, the Nursing and Midwifery Council (NMC) permit CAM practise with appropriate training, although do not specify what it deems as appropriate. For dentists, the General Dental Council indicate dentists may be involved in CAM and has ethical guidance for this.

In general, the Science and Technology Committee considered these regulatory bodies take a somewhat passive position on the practise of CAM by their members (House of Lords. Science and Technology Committee, 2000, s.5.77) and advise clearer guidelines on competence and standards and that these should be developed.

As has already been discussed, the medical schools provide little in terms of formal hypnosis training sufficient for practice, although Kline (2006:36) suggests medical and dental school are beginning to provide training, albeit on a limited basis. This may be more focused towards raising awareness than practitioner competence. Meares considers one of the most pressing problems is to convince those who are responsible for policy making in medical education of the need for medical training in hypnosis, at undergraduate (understanding / awareness) and postgraduate (application) levels (Meares, 1961:466). Until this happens, the extent of training undertaken to achieve competence is unclear. This is observed by the White Paper on CAM regulation. Hambleton (2002:7) suggests that hypnotherapy training is largely provided by private enterprise. Although this was purported some eleven years ago, the lack of later relevant research inhibits accurately reporting the current view. Informal perusal of the training offered in popular press, on the internet and training providers' websites, appears to support Hambleton's assertion.

Section 6.87 of the White Paper (House of Lords. Science and Technology Committee 2000) discusses the "controversy" about whether doctors who want to train in a specific CAM modality, such as hypnotherapy, need to undertake the same training as a non-medic student, with doctors asserting they don't need to cover anatomy and physiology. It can be noted that the British Society of Clinical and Academic Hypnosis (BSCAH) training, for, amongst other medics, doctors, is just three weeks in duration, as compared to 120 classroom hours and 450 total study hours suggested by the Core Curriculum. Furthermore, a comparison between the syllabus published on the BSCAH website (British Society of Clinical and Academic Hypnosis, 2013) and the H.NOS would indicate areas where the training could be more comprehensive. It would seem reasonable to calculate that the 120 classroom hours do not include 84 hours of anatomy and physiology and thus do not justify a reduction in training duration to three weekends (36 hours). Furthermore, it could be argued that practical work, integration, and synthesis of learning are casualties of such a large reduction in training hours, thus

leading to poor outcomes in terms of lower knowledge base, reduced understanding and weaker skills, resulting in reduced confidence and therefore less likely to use and develop their skills, knowledge and understanding. The report does go on to acknowledge that there is often 'limited communication' between the medically based and non-medically-based CAM bodies (House of Lords. Science and Technology Committee, 2000:112).

However, although the report specifically recommends (House of Lords. Science and Technology Committee, 2000, s.6.95) that regulatory bodies should develop schemes whereby they accredit certain training courses aimed specifically at doctors and other healthcare professionals, little has been seen of this from the CNHC yet. Although there are H.NOS and now, most recently (late 2012), a Core Curriculum, it would appear that these have not been adopted by BSCAH, one British professional body who only accept trained medical practitioners and conduct their own training. It can be observed that neither H.NOS nor the Core Curriculum are mentioned at all in their syllabus (British Society of Clinical and Academic Hypnosis, 2013). Broader and deeper training, better reflecting the requirements of H.NOS and the Core Curriculum is available in the UK for medical practitioners. Some training schools, such as the London College of Clinical Hypnosis (LCCH), offer separate training courses for medical professionals. Their eight-weekend course is similar to the sixteen weeks that lay students attend, yet with anatomy, physiology and in-depth training of conditions and symptoms excluded from the medical course, assuming prior knowledge.

There are further issues relating to training of healthcare professionals other than doctors. The White Paper report indicated (House of Lords. Science and Technology Committee, 2000, s.697) there was little evidence of student nurses being exposed to the practice of CAM therapies. The report quotes the Royal College of Nursing (RCN) as saying "*there is no formal facility for awareness-raising of Complementary therapies within the core curriculum...*" despite nurses being most likely, according to the report, to use CAM techniques in their day-to-day activities. Although the report does not raise concern about the quality of CAM training available to doctors, in Section 6.101 it raises concerns that nurses may be exposed to 'inferior or superficial training programmes' and that they may practice without adequate supervision of this component of their work. This would appear supported by the concern of the RCN

(Section 6.105) regarding the variation in the quality of CAM training to which nurses may be exposed.

It can be viewed as curious that the medical profession are so keen to guard access to use of something that, for many years, was condemned by the medical profession as being unscientific and bordering upon charlatanism and quackery (Hartland, 1975). Although Connolly (2007:11) does suggest that modern Western psychiatry and psychotherapy are partly derived from the earlier healing methods of magnetism and hypnotism.

The 1970s were a time of growth for lay practitioner hypnotherapy training schools. As early as 1976, Kroger and Fezler (1976) recognised a need to see a greater interchange between different branches (approaches) of therapy, although a key argument by the medical practitioners against lay practitioners is the potential for failure of a complementary healthcare practitioner to identify a serious medical condition. This is a risk that has concerned medical observers such as Ernst (Ernst 1995), although Mills (1996:49) suggests a perception that most patients present for complementary therapy after having received medical attention. Furthermore, some major psychological disturbances, such as schizophrenia, psychosis or severe personality disorders may certainly be limited to licensed psychotherapists as Churchill (2002) suggests.

The lay hypnotherapy branch does have some areas for improvement. Mills (1996:49) suggests the major professions (medical) have reporting schemes for 'adverse-effects'. Despite suggesting these are lacking, thereby supporting the view of Griffin and Weber (1986), it would seem that there are no such formal schemes in place for hypnotherapy lay practitioners. Mills (1996:49) also suggests that whilst complementary therapists might say they do not 'diagnose', that their 'assessment' could be misinterpreted and draws attention to issues relating to assumptions of responsibility.

Section Summary

This section has considered a range of perspectives on what hypnosis is and how we are yet to have a single, agreed, all-encompassing definition. It has been shown that through history, hypnosis has been considered in a number of different ways, and this is true of hypnosis theories (see Appendix A) that inform the view of what hypnosis is. The historical and theoretical influences, together with traditional and contemporary

research, inform the prominent debates within the hypnotherapy sector, including the state/non-state debate and the medic / lay practitioner debate. It can be considered that the state/ non-stage debate may influence how practitioners select their therapeutic approaches and describe hypnotherapy to others. However, the medical practitioner / lay practitioner debate could be seen to be deeper, an aspect which is really concerned with whether lay practitioners should practice at all, on one hand, and whether medical practitioners are sufficiently trained, on the other. The next section considers research, application and modes of practice. Medical and lay practitioner practice is also explored further in detail.

2.3. Research, application and modes of practice

The predominance of hypnosis research, both in the UK and Internationally, is focused towards the application of hypnosis in the treatment of conditions, such as the use of hypnosis in pain management, or for assessment purposes with individual differences, such as whether mindfulness or state or trait anxiety influence hypnotic susceptibility. However, many working hypnotherapists may have little access to opportunities to engage in the research process and the medical practitioner / lay practitioner debate in considered further in both the hypnosis research sub-section (2.3.1) and following applications and practice (2.3.2) and modes of practice (2.3.3). The applications of hypnotherapy have a broad scope of use, yet there are still perceptions of dangers and others debate whether hypnosis is a therapy in its own right or an adjunct to other therapies. However, the broad modes of practice would appear to support extensive use of hypnotherapy in the UK.

Hypnosis research

As discussed in the definition (Review of Literature) hypnotherapy is considered by some to be a ‘complementary therapy’ or ‘complementary medicine’. Such a view is supported by House of Lords, Science and Technology Committee report on CAM (2000) which does acknowledge hypnotherapy and places it in ‘group 2’ relating to the extent of regulation and evidence. Some scientists and doctors consider CAM procedures and efficacy should be subjected to scrutiny by conventional science (House of Lords. Science and Technology Committee, 2000, s2.22) and ‘how’ conventional science is applied is perhaps more flexible than before, with the advancement of

quantitative research approaches. For example, Burgess *et al*. (2006) suggest the process of reflection will help to make sense and develop theory out of what is known and believed in. Evans (2002) suggests conceptual clarity is an essential methodological tool, with a conceptual framework being the scaffold, framework of ideas, questions, theories, methodologies and methods under-pining research (Burgess *et al.* 2006).

It could be suggested that there are relevant links between the professional context and areas of knowledge and understanding, thus connection between context, theory, practice and research. Usher and Bryant (1989) do question to what extent do theory, practice and research depend on each other and suggest a 'Captive triangle' of theory, practice and research. Therefore, there is a potential, with widespread following of H.NOS for this captive triangle to become consistent.

From a research background perspective, the benefits or advantages, or the influence in any way, of the H.NOS appear less clear. The H.NOS apply to the therapeutic application of hypnosis, yet they are not specifically related to the use of hypnosis in research. Furthermore, researchers using hypnosis may not have undertaken the depth of training required to meet the H.NOS. Yet, such researchers are using hypnosis in research that will then inform the hypnotherapy and wider professions. Thus, it could be argued that it is reasonable for researchers to have attained an appropriate skill and knowledge base to apply when testing and exploring gaps in existing knowledge.
The White paper for CAM regulation suggests that in some areas of CAM, little research is applied, and where it is, these are give disproportionate weight (House of Lords. Science and Technology Committee, 2000, s.4.5). The White Paper suggests, at that time, a lack of evidence of high quality CAM research (House of Lords. Science and Technology Committee, 2000, Summary XII). It is perhaps not the lack of publication avenues as, in recent years, there have been the development of several respectable journals, such as Complementary Therapies in Clinical Practice, Complementary Therapies in Medicine and Complementary Therapies in Nursing and Midwifery which regularly publish peer-reviewed research. Furthermore, CAM research appears in a wide range of allied journals, including the BMJ (Mills, 2001, Zollman and Vickers, 1999).

The medic/ lay practitioner debate may continue through to research, as lay practitioners are excluded by the Hypnosis and Psychosomatic Medicine branch of the Royal Society of Medicine, and from BSCAH, both of whom have conferences and academic opportunities. The White Paper does suggest the lack of research may be due to a lack of research training, poor access to research funding and a lack of research infrastructure within the CAM sector. It is suggested that new routes in academia develop as the professionalisation of hypnotherapy develops. This may be aided by the recommendations of the White Paper which indicate a need for a 'central mechanism' for co-ordinating and advising on CAM research and for making available research training opportunities be established, with resourcing from the Government and, possibly, the charitable sector. Such a body could implement various means of aiding CAM research. The White Paper suggested that research training is incorporated into the curriculum of all CAM practitioners, which would lead to 'a new cadre' of research-aware practitioners, but recognises this may take time and suggests in the meantime that existing practitioners access some research training (House of Lords. Science and Technology Committee, 2000, s.6.48).

Training CAM practitioners in methods and principles of appropriate research disciplines will undoubtedly increase research activity in this area as will attract mainstream investigators into CAM research. This will only happen if sufficient funds are available and an appropriate academic infrastructure is established (House of Lords. Science and Technology Committee, 2000, s7). However, it is to be hoped that such a structure will be accessible to both medical and lay practitioners. Section 7.33 of the White Paper indicates the compilation of a database of appropriately trained individuals who understand CAM practice. This could be a positive step forward for practitioners who are both experienced in their field (such as hypnotherapy) and have research knowledge and skills. However, the report also talks of funding going to centres of excellence in, or linked to medical schools, and these are likely to be inaccessible to many lay practitioners (section 7.57). The report appears to anticipate this by acknowledging many CAM practitioners are in the private sector.

The White Paper (House of Lords. Science and Technology Committee, 2000, s.4.3) refers to evidence from the Academy of Medical Sciences who raised concern that many CAM practitioners do not take a 'scientific' approach to treatment.

Weitzenhoffer (1989:3) suggests that therapists can approach hypnotism with a scientific spirit and a critical mind. It could be argued that with a lack of access to resources, as discussed earlier, together with often-inadequate methodological approaches to accurately measure efficacy of the relevant processes that this is hardly surprising. It could also be suggested that many medical treatments are on a 'try it and see' basis. The White Paper does refer to evidence from Sir Iain Chalmers, Director of the UK Cochrane Centre which would seem to support this, by suggesting that conventional medicine is biased against CAM and Battino (2007:15) does indicate that for some people the word 'scientific' in relation to alternative (not complementary) therapies is a contradiction in terms. However, it can be recognised by an exploration of contemporary hypnosis research, such as Contemporary Hypnosis and Integrative Therapy Journal and the European Journal of Clinical Hypnosis, that hypnosis is taking an increasingly scientific approach.

To some extent, it can be considered that the hypnotherapy field has had to wait for science to sufficiently develop to be able to effectively measure aspects of hypnotherapy. Pettinati (1988) suggests that for over a century there has been a widely held belief that hypnotherapy is effective in the regaining of forgotten memories with the application of hypermnesia approaches. Furthermore, Pettinati suggests that whilst this was a belief that previously relied of practitioner experience and clinical reports, it is now supported by a decade of empirically sound research. The science eventually caught up with the practice. Moorehouse (2008:58) suggests that the 'cycle of discovery' is spinning faster than ever considered possible, with new scientific development emerging every day and new material to read and digest, refreshing learning and gaining deeper understandings (Morrison, 2004).

The transition of research from the 'real world' to the laboratory and from the laboratory to the 'real world' can be widely debated. Hambleton (2002:72) suggests hypnosis in a laboratory setting (is associated with minor and transient adverse effects. However, many of the professions leading theorists and experts have spent time in research laboratories, traditional setting from a psychological history viewpoint), such as Pavlov (1927, 1957) who worked, trained and learned in a laboratory. Weitzenhoffer (1965) considered that prior to Clark Hull's research published in 1933 (*Hypnosis and suggestibility: an experimental approach*) (Hull, 2002), well organised or well-designed

studies were rare and scattered. Gregory (1987:328) supports this considering Clark Hull heralded the start of the modern era into the study of hypnosis with experimental hypnosis rapidly expanding in the 1950s and 1960s with F X Barber, ER Milgard, MT Orne and TR Sarbin and the Stanford Scales of AM Weitzenhoffer and ER Hilgard in 1961. However Barber *et al*. (1974:140) commented that a conspicuous characteristic of research in the area of hypnotism is its relative isolation from empirical and theoretical work in other areas of psychology.

Perhaps it is the very nature of hypnosis that makes it so challenging to scientifically research. Griffin and Tyrell (2001) ask how a state can be so easy to observe and be induced in so many, have often apparently contradictory ways and be so little understood. Perhaps also it is that most practicing hypnotherapists do not have access to appropriate research facilities. For example, a laboratory-based study by Carter (1998:318) on mapping the mind, which indicated increased activity during hypnosis, could only be conducted in the laboratory. That some evidence could only be sought in appropriate research facilities is further supported by the work of Horton *et al*. (2004) who reported the first experimentally controlled MRI research demonstrating differences in brain structure sizes between low and high hypnotisable persons. The use of MRI; stringent screening for hypnotisability, with two scales and tests (Watkins and Barabasz, 2008) and associated resources and facilities are beyond the reach of many practitioners.

Hilgard (1970) suggested the study on which his book was based was only possible in the team setting of a large laboratory. Other such examples would include Wolpe's use of drugs for specific deconditioning (Wolpe, 1973:189) Rossi and Nimmons (1991) research into hypnotherapy and ultradian healing response, and even Liebeault's experimentation with telepathy and hypnosis (McGill, 2004a,b). It is perhaps also a suitable environment for monitoring sensitive or contentious research, such as that of Wolpe (1973:258) investigating reversal of homosexuality after overcoming general inter-personal anxiety. A transition of information between the laboratory and its generated work and clinical practice can be conflicting. Hunter (1994:5) suggests that whilst hypnotisability is a key factor in research, motivation is the primary factor in clinical practice.

Kroger and Fezler (1976:12) suggest that it is the hallmark of a scientist to define his terms, for only then can semantic confusion be eliminated and it could be argued that definition of such terms, and the reduction of confounding variables, is more easily achieved in a controlled environment. However, practice based and workplace based research is starting to have a profile in contemporary journals, such as that of Fewell and Mackrodt (2005). Gordon (1967:609) suggests the ethical problems that attend research and practice with hypnosis are not very different from those of any service or scientific profession that deals directly with human beings. Although, Erickson and Rossi (1989) question the limitations of post-hoc case analysis, questioning the extent to which the highly intuitive therapeutic engagement of a brilliant clinician could be understood in the light of a later cognitive analysis.

With consideration of these arguments, there is some interesting hypnosis research starting to be published, which has relevance for the practitioner as well as the academic. Topics relating to the brain seem popular, such as plasticity in the brain in hypnosis (Halsband *et al.*, 2009), mirror neurons and empathy (Antonelli and Luchetti, 2010) and the hypnotic brain, linking neuroscience to psychotherapy (De Bededittis, 2012). In addition, current 'hot' topics include mindfulness, such as Harrer's Mindfulness and the Mindful Therapist (Harrer, 2009). Practice and technique related research is also well received, such as for depression (Alladin, 2009), Davis (2010) report on the union of ego state and Ericksonian therapy, the use of desensitisation for phobia (Kraft and Kraft, 2010) and treatment of post-traumatic stress disorder (Ibbotson and Williamson, 2010).

Benson (2001:77) suggests hypnosis is a widely known but still poorly understood technique, and this could be partly due to the consideration that no two people have exactly the same experiences (Bandler and Grinder, 1975). However, Erickson and Rossi (1981:90) suggest hypnotic trance is a state of awareness wherein the normal organising and structuring function of the left hemispheric consciousness or the ego is minimal. Furthermore, Holland (1993:181) talks of hypnosis as more a simple reprogramming of the reticular activating system. From a deeper medical and scientific perspective, Bodenhamer and Hall (2007:177) consider hypnotic trance occurs during the theta level of sleep when the brain's neuro-transmitter chemical acetylcholine dominates instead of norepinephrine. When this happens, an individual tends to pay

more attention to internal information in stored patterns in the brain such as memories, instead of sensory input from the environment. Such differences of opinion can make training difficult!

Application and practice

The scope of hypnotherapy use

With the development of cognitive sciences and an increase in research, the evidence body for hypnotherapeutic applications is growing in public awareness. It can be considered that society in the UK is developing more awareness of and engagement in personal health and wellbeing, as can be seen by the increased exposure of related topics in the popular media and the growth in numbers, range and accessibility of practitioners. *The Complementary and Alternative Medicine Journal* (CAM Journal October 2012) in its 10th anniversary issue highlight some of the significant changes in the past ten years, including perceptions of 'lifestyle medicine' and 'integrative medicine', with a 'huge increase' in the number of trained practitioners (p48), greater integration of therapies (p46) and a 'groundswell of evidence and data, with consumers more aware (p47) more health conscious and more discerning (p49).

Whether looking beyond conventional Western medicine to 'alternative' (instead of conventional Western medicine) or 'complementary' (alongside conventional Western medicine) therapies, suggests there is a need for clarity to enable the public to make informed choices. It could be suggested that the National Health Service (NHS) and National Institute for Health and Clinical Excellence (NICE) in recognising the use of hypnotherapy in the treatment of Irritable Bowel Syndrome (IBS) are promoting a wider patient choice. Furthermore, the NHS Careers website discusses the government's commitment to developing the NHS to respond to the needs and wishes of patients and accepts that some patients wish to receive hypnotherapy.

More individuals now seek their own healthcare solutions, rather than wait for a referral from their doctor. If an individual seeks physiotherapy or an osteopathy treatment, they will be treated by a practitioner who is trained to a specific standard, and this is required for them to be able to practice in their regulated profession. For other roles, there are associated 'regulated professional titles' such as Chartered Safety and Health

Practitioner. Yet seeking a hypnotherapist is less simple, as it is not a registered profession, nor holds a registered professional title.

Government publications do not seem to agree fully in a definition of the scope of application for hypnotherapy. The House of Lords White Paper from the Science and Technology Committee 1999-2000, in their Sixth Report, on Complementary and Alternative Medicine (CAM) (2000:21) which does attempt a definition of hypnotherapy application, considering it "*The use of hypnosis in treating behavioural disease and dysfunction, principally mental disorders*". This is a somewhat narrow view of the field of hypnotherapy and appears to ignore the well-established analytical and cognitive approaches. In section 4 (Evidence) of the White Paper it indicates therapy which makes specific claims relating to treating specific conditions should have evidence beyond the placebo effect. However, such specifics are not detailed in the above scope of application. Furthermore, in section 2.8 of the White Paper, on the topic of evidence, the report considers those therapies in group two (which includes hypnotherapy) offer help and comfort when supporting conventional medicine and can fulfil an important role, such as in alleviating side effects and in palliative care. This seems to be somewhat unspecific with regards to application, yet in section 4.5 of the White Paper it indicates that where there exists a mass of evidence to support its efficacy the NHS and medical profession should ensure the public has access to it. This would seem to indicate that there already is acceptance of a body of evidence. However, a survey by Mills (2001) reports no immediate likelihood for integration of CAM into the wider medical community. The report considered it would be misleading to view both together, considering such differences in skills and goals. Therefore, it can be questioned whether a profession as eclectic in approach as hypnotherapy, will ever compile a sufficient body of evidence for all aspects of 'treatment'.

'Treatment', as a term, is mentioned in other government publications beyond the White Paper. Promotional material distributed by the British Council (British Council, 2008) indicated their view that hypnotherapy was the 'use of hypnosis to treat a range of disorders'. The CNHC complementary therapy descriptors (CNHC, 2012a) are less explicit in terms of treatment, but broader in scope which includes anxiety related issues as well as the wider performance enhancement in sport and public speaking.

The hypnotherapy literature also lacks a single definition for the scope of application of hypnotherapy. Yapko (1994:5) suggests most of what therapy is about is 'mopping up' and Pratt et al (1988:1) considers much of what is known about hypnosis has not changed in the past 150 years, although modern research and practice has developed the clinical applications of hypnosis and given it the credibility in its long history.

Many theorists agree that a number of factors influence the efficacy of hypnosis (see appendix A1). The role of belief and expectation is recorded back to the earliest of times. The effect of expectation is well reported by Ariely (2009:155-172) who refers to Mark Twain and a quote by Tom Sawyer that to make a man covet a thing, it is only necessary to make it difficult to obtain. The role of imagination is also a key influence, some which Bernheim and Herter (1899:94-98) consider as the powerful worker of miracles. In addition to these influences, Royle (2006:37) suggests two of the keys to hypnosis are disorientation and confusion.

Allen (2007) takes a different approach, suggesting hypnosis is actually a teaching process utilising the capabilities and potential of the unconscious, taking advantage of the ever-increasing knowledge of learning patterns (Allen, 2007). However, O'Keefe (1998:21) considers waking suggestions to the layperson do not seem like hypnosis at all, and Dienstfrey (1991) reports that Barber considers hypnosis no different to any other carefully presented suggestion. Powers though draws parallels between Plato's big three of feeling, willing and thinking, proposing that suggestion corresponds to thinking (Powers, 1961).

The perceived dangers

Despite the low cost of practitioners insurance giving an indication of the risk industry's perception of the scope of risk, talk of 'dangers' does attract media attention and feeds public perception. The LA Times in February 2005 reported that on their streets Russian gypsy hypnotists were making people hand over belongings without question (Brown, 2006). Milton Erickson in Rossi (1980a) did suggest the possibility of misuse of hypnosis for antisocial or criminal purposes, although he considered it depended on the hypnotist as a person, the subject as a person and the influence of the hypnosis upon them (Rossi, 1980a:498) citing a view of Rowland (1939) that there was little likelihood of such a possibility. In the case of the Russian hypnotists, it would seem unlikely that

they encountered a large proportion of highly suggestible individuals, although it does seem more likely that people were scared and handed over their belongings as they would in any other mugging.

Perhaps unwittingly, some authors, it would appear, do draw attention to the potential for danger. Austin's 1994 publication is entitled 'safe' self-help guide. Whilst it suggests (Austin, 1994:23) that danger from hypnosis is the most common belief and the greatest fallacy, but placing the word 'safe' in the title surely there is an implication that others could be 'unsafe' or dangerous. Clinical Psychologist Baruch Elitzur (Segal 2004) suggests the ability to enter into hypnosis is common to the entire human race. Furthermore, Elitzur proposes that it has an important role in the survival of the species. It could be argued, that if the entire human race are able to enter hypnosis, any prominent dangers would be much more widely known and commonly established. Prominent researchers Spiegel and Spiegel (2004:13) reported on a study at a Midwestern university that tested the hypothesis that hypnosis is dangerous. The study found no supporting evidence.

Hambleton (2002:73), in a clinical setting, and Crawford *et al*. (1982) generally, suggest hypnosis is unlikely to produce after effects beyond those of a minor and transient nature, whereas Conn (1972:61) suggests the dangers are those that go together with every psychotherapeutic relationship. However Cheek and Le Cron (1968:67) suggests there are some dangers, which are readily avoided by understanding the possibilities and taking simple precautions. Furthermore, Weitzenhoffer (1989:27) considers there is no evidence that engaging in the hypnotherapeutic process leads to a dependency upon hypnotherapy.

James (2007) considers hypnosis is safe and effective, as control lies in the realm of the recipient, who guides themselves (MacKenzie, 2005:41), thus enabling them even to 'pretend' if they wish (Temes, 2004). However, Ewin and Eimer (2006:14) consider any mythology presents hypnosis as a master-slave relationship that may be threatening to people who are concerned about losing control. This would appear to support the view that, despite evidence to the contrary, many people still express doubts and concerns about potential dangers (Hartland, 1975). These are, in Hartland's view,

completely unjustifiable for hypnosis. He regards hypnosis, in itself, not dangerous if practitioners stay within their field of competence.

A standalone therapy?

Some prominent hypnotherapists consider that hypnosis is becoming the number one form of mental health therapy (Silver and McGill, 2001:171) with Morgan (1996) considering hypnotherapy broader than most forms of psychotherapy, perhaps due to its eclectic nature of drawing from a range of psychotherapeutic models and techniques. However, Hartland takes a narrower view, that hypnosis should not be regarded as an independent speciality replacing other methods of psychotherapy (Hartland, 1975:10). Furthermore, Gafner and Benson (2000) suggest hypnotherapists are primarily therapists, with requisite education and training. There are considerations that support both views. Some individuals using hypnosis may have learned only from books, online courses or DVDs and not had their understanding of underlying principles nor practical skills assessed by an experienced hypnotist or hypnotherapist. Thus Hartland's concern can be understood as it could be argued that such limited practice might not observe wider issues, such as co-morbidity effects. Many therapists have invested their resources into substantial and effective training and have been assessed as having achieved a specific standard, whether that relates to the H.NOS and core curriculum, or a standard set by an educator or professional body. It could be questioned whether such a broad understanding of psychology or psychotherapy is necessary for the very specific approaches that hypnotherapy offers.

The European Society of Hypnosis (ESH) ethical guidelines (European Society of Hypnosis, 2012) consider competence in hypnosis techniques is insufficient for professional service or research and that hypnosis is a psychotherapeutic modality adjunctive to scientific or clinical endeavours. Gill and Brenman (1959:373) do not regard the adjunct use of hypnosis as a separate kind of therapy and consider 'hypnotherapy' is a term that should be dropped from scientific nomenclature. Furthermore, Spanos and Chaves (1989) place hypnotic phenomena within the larger fields of cognitive behaviour modification and social-influence processes. There is ongoing debate, not only regarding the definition of hypnosis, but also regarding its mechanisms of use.

However, Rossi suggests that for too long hypnosis has been misrepresented as the handmaiden of psychiatry and the stepchild of psychopathology (Rossi, 1996:9). Rossi further suggests most schools of psychotherapy have their roots in hypnotherapy. This is supported by Edmonston (1986), Ellenberger (1970) and Zilboorg and Henry (1941). It can be suggested that misconceptions can lead to bias in the professional fields, with hypnosis and hypnotherapy judged erroneously. Keeton and Petherick (1997:9) mention Professor Hugh Freeman who talks of finding the ideas that he, as a professional in mental health, had initially held about hypnosis were mostly wrong and Barnett (1989) would agree that hypnotherapy is a poorly understood subject.

Wright (1987) suggests a blended approach to hypnotherapy with the therapeutic use of the hypnotic state of consciousness as part of a psychotherapeutic intervention in order to enhance the effectiveness of the client's utilisation of psychotherapy. It does not presume to provide a theoretical system that deals with the nature of personality or behaviour, out of which would evolve the strategies for change derived from that system. That is the goal and task of individual systems of psychotherapy, although Lemezma (2007:11) suggests the use of psychology is fundamental to the success of "magical performance".

Rossi indicates that the best way to approach the subject of hypnosis would be through the role of psychological forces in human behaviour (Rossi 1980c: 26). Further that this would allow for the expression of secret ideas. Ellenberger (1970) considered that illness resulted from such secret ideas, a concept first formulated by de Puysegar and used by Viennese physician Moritz Benedict.

It could be argued that psychotherapy and hypnosis remains more an art than a science (Gafner 2004). This could be supported by Evans (2003) and Smith and Glass *et al.* (1980) estimated that approximately 50% of the beneficial effects of psychotherapy were due to the placebo effect, although Evans considers more can be interpreted from the numbers, with some viewing it is the client that does the work in psychotherapy (Lauria, 2009).

Hypnotherapy practice

Historically, the medical profession has condemned hypnosis as being unscientific and bordering upon charlatanism and quackery, often with its investigation and exploitation residing in the hands of unqualified operators and showmen (Hartland, 1966). It would appear it has now graduated and is now accepted as a legitimate form of medical treatment. For example, the NHS' National Institute for Health and Clinical Excellence (NICE) recognise the use of hypnotherapy for the treatment of Irritable Bowel Syndrome (IBS). Furthermore, Burton and Bodenhamer suggest, "all effective therapy seems to involve hypnotherapy" (2004) and it is a time of growth and transformational opportunities for hypnotism (Brookhouse and Biddle, 2006:11). However, there appears to be a divide in the hypnosis and hypnotherapy profession, from a practitioner perspective, between medics (doctors, dentists, nurses) and the lay practitioners. Some medical practitioners consider that only they should be allowed to conduct hypnotherapy. Many lay practitioners consider their wider and deeper hypnosis-specific training more relevant for working with hypnosis clients. There are also divided views in the literature, as shown here, whether hypnosis is a standalone therapy, or an adjunct to medical practice (www.bscah.org.uk), particularly in medical settings (Klapkow, 1996) and for clinical cases (Walker, 1980).

Profile of a lay hypnotherapist

It can be asked who a typical lay hypnotherapist would be, and whether they are full-time, part-time, or combine hypnosis with another therapy. A reputable lay hypnotherapist could be considered one who is suitably qualified, with professional membership (Milne, 2004:224) following the ethical guidelines of their professional association (Fross, 1988:90), suitably insured for their work, and engaged in regular supervision (Clarkson, 1996). They may engage in hypnotherapy in a vast range of environments from private practice to part of a group of complementary therapists, within industry, or within a private or NHS healthcare environment. Some medical practitioners see this latter role as objectionable, raising concerns that the lay practitioners may be regarded as a medical professional by being engaged in that environment and that this would mislead patients. Creatively, Ousby (1984:6) proposed an Auxilliary Medical Register of responsible hypnotherapists who could work under the supervision of doctors. Essentially, it can be considered that a lay hypnotherapist is

one whose primary training is in hypnosis and hypnotherapy and applies this training as a primary therapeutic approach.

Profile of a medical hypnotherapist

The ethical guidelines and insurance provisions for medically qualified professionals (doctors, dentists, and nurses) restrict the application of hypnotherapy to within their role, using it adjunctive to their conventional treatment (House of Lords. Science and Technology Committee, 2000). However, anecdotal evidence from discussions with such individuals whilst at conferences and on training courses indicates that some medics are looking to expand their hypnotherapy work to a 'side-line' for additional income, for a route towards early retirement, or to supplement their retirement. Thus, a dentist may end up working with clients ranging from weight loss, to relationship jealousy and premature ejaculation; none of which is related to their previous role. This could be seen to add to the lay/ medic argument where lay practitioners dispute the breadth and depth of medical hypnosis training as compared to lay training. Lay practitioners may argue that brief training (such as three weekends, (BSCAH, 2012)) does not provide the medical practitioner with the resources to address non-clinical (such as sport performance) or cross-clinical (such as work-related performance anxiety) issues. Thus, it can be questioned whether the inexperienced medic would be sufficient for the entire range of patients who may seek hypnotherapy. Yet some individuals are very focused on only referring to medically qualified practitioners, such as Kermani (1999:295) who refers individuals to medically qualified practitioners, suggesting deeper unresolved issues can be addressed providing the hypnotherapist is sufficiently qualified. A medical hypnotherapist is one whose primary training is medical with hypnosis and hypnotherapy as a secondary form of training and apply this training as a secondary therapeutic approach with medicine being their primary approach.

Who seeks hypnotherapy?

There is little in the literature to identify the demographics which best define those who seek hypnotherapy. It is said (Beck, 1979:215) that those who come to the professional helper and inadvertently acquire the label of 'patient' or 'client', are drawn from the residue who have failed to master their problems. This is perhaps as true today as it was when Beck wrote this over forty years ago. Anecdotally, many therapists can remember

clients who come for hypnotherapy saying it is their 'last resort' and this can prompt those who normally would not 'believe' in a therapy to seek it out. It would appear that people find CAM a suitable resource, with a survey of 2668 adults in England finding 13.6% of respondents had visited a CAM therapist (including hypnotherapy) within the past year (House of Lords. Science and Technology Committee, 2000, s.1.19). However, it may be that individuals are seeking help earlier in their quest to resolve their issues, sometimes before seeking medical help, and this is supported by Philips and Watts (2005) who suggest that people are looking for immediate results. Such a desire for quick or instant results can be challenging for therapists. Certainly Parnell (1998) reported frustrations by what she felt were limitations in her ability to help people and Wolpe (1958:140) adapted his technique and trained patients in relaxation before conducting therapy, considering it more effective. It can be seen that there is no 'standard' hypnotherapy client or patient. Some may choose hypnotherapy as their first approach, others as a last resort. This may provide indications for how the client or patient is treated and their motivation and engagement in the therapeutic process. Furthermore, some clients may seek therapy of their own volition, others, presently less commonly, may have been referred by a medical practitioner.

Modes of practice

Hypnotherapy in private practice

There are no clear estimations of the number of hypnotherapists, whether medical or lay, who offer a private therapy practice. This is partly due to the numerous professional associations, with the potential to be a member of several, and the lack of any requirement to register with any at all. However, being a member of a professional association can appear to the public as an indication of professionalism. It can appear that an organisation recognises the individual as having qualifications sufficient for membership. It can also indicate that the individual is bound by a code of conduct or ethics.

It can be a complex task for individuals to ascertain who is going to be 'right' for them to see. Perhaps, if the CNHC develop their profile and represent a greater proportion of hypnotherapists, with therapists whose training met the requirements of the National Occupational Standards (NOS) and the associated Core Curriculum, then it may be a slightly simpler task in the future. However, then the choice may fall to interpersonal

and other related skills and how the therapist interacts with the patient can vary immensely (Ellis, 2005:26). Charlesworth and Nathan (1997:299) suggests prospective clients investigate their prospective therapists' training and specialism, perhaps checking that the therapist is able to address their goals for therapy, particularly if complex. This follows the suggestion by Sutton and Steward (2009:235) that hypnosis should only be administered by qualified experienced practitioners for more complex issues. Furthermore, this is also supported by Webster (2005:85) who suggests finding a hypnotherapist who specialises in what is required. Hathaway goes further, suggesting the seeking of references (2003:237) for the hypnotherapist in some cases.

Botsford (2007) suggests that hypnotherapists in private practice must actively work to optimise all the elements that influence the client, not knowing exactly when that breakthrough will take place. This can be a challenge when clients are looking for an answer to 'how many sessions will this take?' The successful clinician will build upon classical approaches (Patterson, 2010:212) although the therapist can become aware of their own patterns of behaviour and apply these to clients (Grinder *et al*., 1977:5). Robbins (2001a:13) considers that to empower people to realise that they determine the outcome of their own lives is not always easy; it can be an overwhelming task. However, Robbins (2001b:5) suggests that from an achievement perspective perhaps, suggests the ultimate power is to the ability to product the results you desire most and create value for others in the process, with the ability to define human needs and to fulfil them.

Hypnotherapy in hospital settings

It would seem that very few hospitals appear to have specific in-house hypnotherapists or clinical hypnotists and information could not be retrieved despite several detailed internet searches. However, the London College of Clinical Hypnosis (LCCH) operate a pilot programme, working with hospital volunteer departments in a range of hospitals, placing experienced clinical hypnotists and hypnotherapists in ward and department settings, to offer therapy to patients. It can be noted that these volunteers are lay practitioners. More widely, the use of hypnotherapy in palliative care in receiving positive attention (NHS, 2013a). However, the NHS careers website (NHS, 2013a) seems broader in its description of hypnotherapy use in hospital settings, beyond the NICE guidelines, as it recognises some CAM therapies have helped alleviate symptoms

where orthodox medicine “does not seem to have offered a complete solution”. It then reports a number of NHS hospitals use various CAM therapies and indicate “clinical hypnotherapy may be used to help patients successfully deal with habits, phobias, anxiety, panic attacks, fear, stress, pain management, sleeping problem, concerns with chemotherapy...”

With consideration of the previously mentioned lay / medical hypnotherapist divide, Arons and Bubeck (1971:3) discuss the role of the ‘hypno-technician’ as practitioners of science of suggestion. They suggest that these belong to the ever-growing family of paramedical assistants including the medical, dental and x-ray technicians, nurses and others with specific skills to aid and extend the efficiency of the psychologist, psychiatrist, dentist and physician. Whilst this does not place the hypnotherapist as equal to a medic (for hypnotherapy activities), it does offer an appropriate role.

Hypnotherapy and sport

The use of hypnosis in sport is not widely advertised, whether due to perceptions or ‘trade secrets’ or that it is simply another tool in the sport psychologists’ toolbox. However, some ‘sporting stars’ are now more open to admitting the use of hypnosis to help with performance. The Centre for Sports Hypnosis offer examples of many hypnosis news reports, including: the Pakistan cricket team in 2009 (self-belief and focus); Shot-put champion Alison Rodger (goal focus); Basketball player Dani Dudek (arthritis pain); Ipswich Town Football club and Swindon Town (improve performance); US Karate champion Billy Finegan (confidence post injury); and Rugby League Shontayne Hape (adjust post injury and surgery) (The Centre for Sports Hypnosis 2013).

Whilst the therapeutic benefits of hypnosis and even suggestibility have gained much attention from researchers, it is to be applauded that sport is now also receiving attention from hypnosis researchers such as Dr Marc Jones and Dr Jamie Barker. These Chartered Psychologists and Health and Care Professions Council (HCPC) (statutory regulatory body for psychologists) registered sport and exercise psychologists work with and research across a range of sports and abilities through to elite athletes, particularly looking at the efficacy of hypnosis in enhancing confidence in sport. This

can be of immense value, as many athletes are becoming aware of 'winning the mind game'.

A research review recently published by Barker *et al*. (2013) identified several hypnosis research papers, it reported, "*Two areas where single case research methods and designs (SCDs) have recently driven sport psychology intervention research are in relation to hypnosis... and imagery"*. With hypnosis often being regarded as fundamentally consisting of suggestion and imagery, the two areas mentioned appear closely related.

Hypnotherapy and the military

Although not commonly reported as in use with the UK military, Smith (2005:13) talks of the US military looking into hypnosis as a tool for organisational efficiency and individual growth and Herbert Spiegel recounts having learned hypnosis from Dr Gustave Aschaffenburg, who had been professor of forensic psychiatry at University of Cologne, then as a political refugee in USA, who taught army psychiatrists use of hypnotic techniques at beginning of WW2 (Spiegel and Spiegel, 2004:11).

On a range of hypnosis and hypnotherapy training courses, the researcher has met participants who are from a range of divisions within the military. Whether their participation was from a personal perspective (such as personal development for a second career when they conclude their military service) or from a current service perspective is not known. For example, Arslan (2010) reported on a military court hearing in Turkey about testimony obtained whilst under drugs and hypnosis during interrogation (banned under their Code on Criminal Procedure). It would seem reasonable that the hypnosis skills had been learned somewhere and that such use was recognised in order for its use to be banned. Its use is recognised in the US, particularly with the application of forensic hypnosis where memories have been suppressed due to trauma (Myers, 2012). Furthermore, research is undertake into the use of hypnosis in the military, such as that of Colosimo (1992) who found veterans who were good hypnotic subjects were better at problem-solving in their preparation for post-war transition.

Section summary

This section has explored some of the key issues within hypnosis and hypnotherapy research. Such research may be seen to be fuelling the medical / lay practitioner debate as few practitioners ~~a~~ngage in and publish research. This has been recognised in the CAM White Paper, which supports more access for practitioners. Research tends to be condition and treatment focused, although there can be a divide between the control of the laboratory and the 'real world' and the translation process research outcomes may need to go through to be relevant in practice. The scope of hypnotherapy use and its perceived dangers and applications in practice have been explored, together with profiles of medic and lay practitioners, and who seeks hypnotherapy. The medic / lay practitioner divide continues through to modes of practice as it is explored how hypnotherapy is applied in private practice, hospital settings, sport and the military. The next section explores the CAM White Paper in more detail and it can be seen that there is support for foundation training for all, which would go some way to narrowing the medic / lay divide and may increase access to research opportunities.

2.4 Legislation, Regulation, Standards, Curriculum and Training

There is little in the way of legislation for hypnosis and hypnotherapy, nor is it subject to statutory regulation. However, the sector now has a voluntary regulatory body and profession specific H.NOS. These standards are most recently supported by a Core Curriculum. However, prior to this study, it was unknown whether educators, or even professional bodies, were engaging with the H.NOS and Core Curriculum and training offerings are widely varied.

Legislation, regulation and government influences

A range of Acts and Regulations apply to the practice of hypnosis and hypnotherapy in the UK. For any hypnotherapist, as for any employee, employer or self-employed individual, they have duties resulting from a full range of associated Acts and Regulations under the Health and Safety at Work Act 1974. Just as for employers, there are statutory duties of self-employed, to ensure the health and safety of people affected by their activities. Perhaps less mentioned on many hypnosis training courses, are the provisions of Acts and Regulations relating to consumer protection and trading standards, the most well known being the Trades Descriptions Act 1968, which

addressed the description (and mis-description) of goods and particularly that people tell the truth about goods, prices services. The other key piece of legislation is that of the Consumer Protection Act 1987 that relates to professions that make claims for goods or services that they sell, and this includes hypnotherapists.

The White Paper on CAM regulation (House of Lords. Science and Technology Committee, 2000) also discusses legislation relating to the purporting of cures for specific conditions, such as cancer, as well as relating to the provision of products. However, it can be noted that under Common Law, all hypnotherapists have a Duty of Care towards their patients. Furthermore, where a therapist is self-employed, there is a legal, contractual relationship between the therapist and the client. Also within Common Law is the fundamental right for individuals to practice medicine, as long as they do not claim qualifications they do not have and thus contravene the Medical Act (House of Lords; Science and Technology Committee, 2000, s.5.9). Although Times view (2004:355) indicates where hypnosis is not a licensed profession (p355) even a dog may be able to claim to be a hypnotist. Despite these areas of contradiction, it can be suggested that where practitioners are registered with any professional body, they will be aware of what constitutes ethical conduct.

Perhaps of little relevance to hypnotherapists and those using hypnosis for therapeutic purposes, but worthy of a mention by its uniqueness, is the Hypnotism Act 1952. Although public interest in hypnotism is reported to have started around 1946, Ousby (1984:59) suggests the Hypnotism Act ended most public demonstrations. This Act relates solely to the provision of hypnosis for the purposes of entertainment. A key component of this legislation is section 6 which, whilst defining what 'hypnotism' includes also states 'does not include hypnotism... which is self-induced'. Thus, stage and entertainments may say to their audience that 'all hypnosis is self-hypnosis' and consider this exempts them from the legislation requirements which include licensing and insurance. In the UK, the provision of stage hypnosis by hypnotherapists is 'frowned upon' by many lay and medical professional societies, although some of the smaller ones are less demanding. It would appear that entertainment hypnosis is regarded as in conflict with the professionalism of a therapy practitioner. It could also be considered that ethical presentation of entertainment or stage hypnosis can reach a broad audience and educate a wider public as to the potential benefits gained

therapeutically from hypnosis. Informal discussions at recent National Guild of Hypnotists World Education Conferences in recent years (August annually, Marlborough, USA) revealed that many practicing therapists in smaller towns have dual roles of therapist and entertainer an aspect successful in that environment.

As previously mentioned, there is no direct legislation relating to the provision of hypnotherapy. Yet it would appear that government focus is well received as the 'Call for Evidence' for the White Paper on CAM regulation resulted in a "huge amount" of written evidence and resulted in 55 oral hearings and was so diverse it considered evidence from CAM applications in dental and veterinary practice. The published report considered CAM use in the UK and USA, the reasons for using CAM, descriptions of CAM Disciplines, reports on patient satisfaction, evidence, regulation, professional training and education, research and development and current modes of delivery. Several aspects of this report are discussed throughout this entire chapter.

In the UK, there are professional and lay voluntary regulatory bodies. Health professions, such as clinical psychologists, are regulated by the Health and Care Professions Council (HCPC). The GMC regulates doctors, the GDC for dentists and nurses by the NMC. Complementary and alternative therapists are now able to register, under their therapy, with the CNHC. In order to practice, particularly in the NHS, relevantly qualified individuals must be members of their appropriate regulatory body.

It is perhaps not well known that there exists a Common Law right to practice medicine (House of Lords. Science and Technology Committee, 2000, s.5.9). This means that anyone can treat a sick person even if they have no training at all, as long as the individual has given their informed consent. Whilst this may seem reasonable in treating minor heath issues, such as a cold in the home, or caring for a relative, this right goes further. Provided an individual does not claim to be a medical practitioner, or claim to cure or treat certain diseases proscribed by law, they can profess to treat a range of disorders. It is said that this Common Law right arises from the fundamental principle that each person can choose the type of healthcare they require (Mills, 2001). Thus, although regulation, whether voluntary or statutory, may apply to specifically named therapies, such as hypnotherapy, any individual may simply use a variation of the name, such as 'hypnotic-specialist', which is then not regulated. It could be argued

that regulation will be less likely to influence those practitioners who are not ethical or working within good practice, as they simply will not be registered with a regulator. However, it could also be suggested that, for ethical and competent practitioners, registration with a regulator can enhance their profile and that of the professional title of 'hypnotherapist'. Furthermore, if the view of Voit and Delaney (2004) is accepted, that there existed (in their time) apparent large numbers of poorly qualified and laypeople who practice hypnosis and that virtually anyone can learn to induce a trance, it would appear that some effects towards control of the profession is relevant.

Regulation of hypnotherapy is relevant to this Review of Literature chapter, as one of the key functions of regulation is to determine a standard of competence, and for hypnotherapy these are H.NOS and the associated Core Curriculum. For practitioners to be able to register with the CNHC they must demonstrate to their verifying organisations that they meet these standards.

This section explores a range of factors upon the journey towards regulation, starting with a Government White Paper on Complementary and Alternative Medicine (CAM) in 2000 and then considering key stakeholders in the process, resulting in the formation of the Complementary and Natural Healthcare Council (CNHC) and the opening of its register for Hypnotherapy.

There are government influences concerning the influence of two significant White Papers. The House of Lords Select Committee on Science and Technology published their report of their enquiry into complementary and alternative medicine (CAM), on 21st November 2000, as has previously been mentioned in this chapter (House of Lords. Science and Technology Committee, 2000). This report recognised CAM use is increasingly widespread and thus raises questions relating to public health and protection. Issues considered included regulatory structure, evidence bases, information sources on CAM and sufficiency of practitioners' training. Such issues will influence any NHS provision of CAM.

The key implications for hypnotherapy are that the report indicates an awareness of ranging regulatory structure, with a fragmented profession and little agreement about regulation or a move towards structured regulation. The report calls for regulatory

bodies to develop competence and training guidelines on CAM, recognising that presently training varies and that accredited training is vital, although as yet, little evidence of this is visible. There appears also to be encouragement from the House of Lords to encourage more practitioners engage in hypnotherapy research to support the current evidence base.

The White Paper (House of Lords Science and Technology Committee, 2000) had a number of recommendations relating to CAM including training and education, information, and research and development and these are discussed in other sections within this chapter. Therapies were classified into three groups, the first, those with or moving towards statutory regulation, the third, those that presented little empirical evidence of efficacy and were considered too far from viable regulation at present. Hypnotherapy was located in Group 2, with therapies such as aromatherapy, reflexology and healing. Chapter 5 of that report discussed regulation of practitioners, with 'Group 2' therapies, which included hypnotherapy, recommended to come together under a single voluntary regulatory body. The report indicated that a good voluntary regulatory structure, with unification under a single professional body, was necessary before a profession could seek statutory regulatory status under the Health Act (Section 5.25) or by pursuing its own Act of Parliament (Section 5.25). At present, no such unification existed, thus the recommendation in Section 5.23 was for a single professional body for each therapy. The concept of a single umbrella body was not universally well received, with some evidence, received by the Science and Technology Committee; raising concern that some the organisations within the umbrella would have insufficient expertise or thoroughness in regulating that particular area (Section 5.67).

It can be noted that the White Paper suggests the principal purpose of regulation is to protect the public from inadequately trained or unqualified practitioners and provides a structure upon which the public can rely and have their rights protected (Section 5.1, 5.14) a sentiment echoed by the CNHC and of interest to those considering the professionalism perspective.

A widespread call for evidence resulted in a vast quantity of written responses and oral hearings. It was noted in Section 5.2 of a 'widespread consensus' of the benefits of

appropriate regulation. Furthermore, Budd and Mills (2000a) suggest regulation would have positive collateral benefits including 'improved professional status and respect'.

The White Paper, in Section 5.68-5.85 report that the regulation of conventional healthcare professionals practising CAM has a different position to that of CAM practitioners. Each of the professions such as doctors, dentists and nurses has their own regulatory body that requires them to practice 'within their own competence'. The report indicates a view that these bodies take "quite a passive position on their members practising CAM" (Section 5.77) with none having clear guidelines for those practising CAM and thus an unclear position for those professionals. Furthermore, it indicates a 'weakness' by the lack of communication between the medical practitioner bodies and the CAM practitioner bodies (Section 5.81) and recommend closer collaboration (Section 5.83).

The second white paper of significant influence is the White Paper: Trust, Assurance and Safety – Regulation of health professionals in the 21st Century (Great Britain. Secretary of State for Health, 2007) which considered a programme of reform for the regulation of health professionals. It included an exploration of governance and accountability of professional regulators, their role in education and information, together with addressing new and emerging roles. A section of particular relevance is 'Risk-based regulation' (points 23-29) with a balancing of the costs (such as time away from patients) of meeting the requirements of regulation. This is of particular interest for some hypnotherapists who discuss, informally, their concerns that regulation will result in less patient contact time. The Regulatory Influence Assessment accompanying the White Paper indicates some of the benefits and risks found in the field of professional regulation. It would be of considerable interest for such risk-based focus and assessment to be applied to CAM regulation, particularly as a proportion of therapists are part-time. It can be questioned whether the cost of regulation compliance was just too much in proportion to their potential treatments. This White Paper did influence the federal working group (Federal Working Group 2008:6), particularly relating to structure, transparency and independence.

Contributors to voluntary regulation

Several organisations, some funded or part funded by government initiatives, contributed towards the voluntary regulatory process. These include the Prince's Foundation for Integrated Health and Federal Working Group; the UK Confederation of Hypnotherapy Organisations; the Working Group for Hypnotherapy Regulation and Hypnotherapy Regulatory Forum. These organisations are explored in terms of their role and contribution to the process.

The Prince's Foundation for Integrated Health (FIH) and the Federal Working Group (FWG) appear to be referred to by a range of names including the Wales Foundation for Integrated Health; the Prince of Wales Foundation for Integrated Health, and the Prince's Trust Foundation for Integrated Health.

In response to the White Paper on CAM (House of Lords Science and Technology Committee, 2000) the Department of Health (DoH) sought the assistance of the FIH to facilitate the process of developing a 'federal umbrella regulator' for the Group 2 therapies. It is reported that £900,000 was granted by the DoH over three years from 2005 to 2008 (Foundation for Integrated Health, 2012).

A single regulatory body for CAM was clearly supported in a report (Stone, 2005) and a consultation exercise (Jack, 2006) was commissioned by the Prince's Foundation for Integrated Health (Federal Working Group, 2008). In October 2006 the FIH invited twelve CAM professions to work together to develop such a system. Hypnotherapy was not one of the original twelve and by December 2007, three professions had left the group. Their final meeting was 18 December 2007. It is perhaps curious that hypnotherapy was not one of the original twelve, even though at the time had a body of research to support its' therapeutic approaches.

Prior to the formation of the CNHC hypnotherapy practitioners were regulated by individual professional bodies and societies. In 1998, a group of hypnotherapy organisations formed the UK Confederation of Hypnotherapy Organisations (UKCHO) that represented a number of professional bodies (British Council, 2008) and became one of the more recognised and discussed groups of professional bodies.

The White Paper on CAM regulation (House of Lords Science and Technology Committee, 2000) in discussing the current regulatory status of CAM professions referred to a survey conducted in 1999 by Mills and Budd at the Centre for Complementary Health Studies, Exeter University, for the DoH (Budd and Mills, 2000a) indicated the professional organisation of hypnotherapists is complex, with overlaps with psychotherapy, wide variations in educational standard, practice and membership. Budd and Mills identified seventeen professional bodies, five of which are members of UKCHO.

It would appear UKCHO maintained a relatively low public profile until the time of their first newsletter, dated January 2006 (UKCHO, 2012) in which they report an agreement between all the 'major umbrella organisations and professional bodies within the field of hypnotherapy to work together through the FIH. The FIH, they report, was commissioned by the Government to assist the professional organisations in the complementary medicine field to develop and maintain statutory or voluntary regulatory systems.

It was thought by the UKCHO that the agreement would represent over 80% of UK hypnotherapy practitioners. At the UKCHO meeting, sponsored and supported by the FIH, on 9th February 2006, it was agreed, by the hypnotherapy organisations present, to form a 'Hypnotherapy Joint Working Group' (HJWG) to develop proposals for voluntary self-regulation of the hypnotherapy profession.

The third UKCHO newsletter, of May 2006 (UKCHO, 2012) reported on the Consultation Document created by the FIH. This considered the structure of the 'federal model' of the then HPC, (now called the Health and Care Professions Council (HCPC)), as a suitable structure for the regulation of complementary healthcare. The report envisaged a single 'Council for Complementary Healthcare' that would represent a range of complementary therapies.

By October 2006, the UKCHO newsletter (UKCHO 2012) reported an alternative group 'The Working Group for Hypnotherapy Regulation' (WGHR) challenging the recently formed 'Hypnotherapy Joint Working Group'. However, in their January 2007 Newsletter (UKCHO, 2012), UKHO reported this group would not be responsible for

regulation as the FIH confirmed they were considered the only body responsible, on behalf of the DoH and the Government, for progressing hypnotherapy through to professional regulation and that this would definitely be voluntary, not statutory regulation. However, the Government also proposed, in its White Paper on regulation of health professionals. (Great Britain. Secretary of State for Health, 2007) that psychological therapies would be subject to statutory regulation (Chapter 7:2), which may certainly have caused confusion for some.

The UKCHO May 2007 newsletter (UKCHO, 2012) announced the creation of their National Register of Hypnotherapists, which would be launched on 1st January 2008 for practitioners accredited and certified by their respective UKCHO member organisations as being to the necessary standard of professional competence and proficiency. It could be questioned why such a register would be needed with the voluntary regulatory body creation almost imminent. However, it was a 'free' service to hypnotherapists and collected what could be a useful starting point for CNHC when they were ready to take over the list. The UKCHO subsequently gave registrants the choice to opt out of having their information passed over for the CNHC to approach them with an invitation to register. This was a choice followed by many professional bodies, with members either having to 'opt in' or 'opt out' of having their name provided to the CNHC.

In April 2008, UKCHO's newsletter (UKCHO, 2012) reported that the FIH has announced plans for the establishment of the CNHC. This was expanded upon in their August 2008 newsletter (UKCHO, 2012), reporting on the CNHC's first meeting with the hypnotherapy professional associations, which UKCHO attended.

The UKCHO and the Working Group for Hypnotherapy Regulation (WGHR) agreed 'professional unity' in January 2009, following a meeting at the FIH on 9th December 2008 (UKCHO Newsletter Issue 14) (UKCHO, 2012), stating the intention to work together for the purposes of voluntary self-regulation. This was further developed by the formation of a joint Hypnotherapy Regulatory Forum, reported by UKCHO in March 2009 (newsletter issue 15) (UKCHO, 2012) as representing almost 90% of hypnotherapy practitioners in the UK. A later example of this unity is with the positions held currently on the CNHC Profession Specific Board (PSB) for hypnotherapy that advises the CNHC on education and professional matters. Currently

this includes a member from each of the two groups. The first meeting of this group was held on 17th November 2010 and posts are for three years, after which nominations for election to the PSB will be sought from CNHC Registered Hypnotherapists. Thus it can be considered that UKCHO had a lasting influence in both its role in the formation of the CNHC and its ongoing development.

Another contributor to the regulatory process was the Working Group for Hypnotherapy Regulation (WGHR) who were initially formed by the General Hypnotherapy Standards Council (GHSC) and the Hypnotherapy Society, to focus on professional standards and voluntary self-regulation (VSR). Their primary goal achieved, the GHSC website (ghsc.co.uk) indicates the working group is temporarily dormant and that its duties will be carried out by the GHSC, in full co-operation with the Hypnotherapy Society, to maintain its role within the Hypnotherapy Regulatory Forum (HRF). It can be questioned why this group became 'temporarily dormant' and not disbanded. Members of the group were surely selected for their ability to contribute to the primary goal, which was achieved. Any subsequent goal may require a difference range of skills and knowledge.

The Hypnotherapy Regulatory Forum (HRF), was partly funded by the Department of Health, with a grant of £10,000 for set-up and running costs, which included a £4000 (plus travel) honorarium for a Lay Chair (British National Register of Advanced Hypnotherapists 2009). Members of the HRF contributed to the establishment of the CNHC and continue to offer support. It is interesting to observe that some groups and forums, such as the HRF were able to obtain funding, yet others were not. In addition, it can be questioned whether funding particularly for a Chair position, influences the motivation of those participating.

Regulation

The regulatory field has several organisations, each with discrete roles and remits. The Complementary and Natural Healthcare Council (CNHC) is the voluntary regulatory body for many complementary therapies including hypnotherapy. They have recently applied to the Professional Standards Authority (PSA) to be recognised as an AVR,

Accredited Voluntary Register. The PSA, who regulate statutory regulatory bodies, such as the HCPC and the GMC, have also opened up to voluntary regulatory bodies. This section also considers the contributions of verifying organisations and professional bodies as the first level of regulation.

The Complementary and Natural Healthcare Council

The CAM White Paper led the FIH to co-ordinate a group to establish a regulatory system. Initially this was to be single discipline registers, following the path of other individual therapies such as Osteopathy, although, following the Stone report (Stone 2005) the agenda changed to a single federal body for a number of therapies. The FWG chaired by Dame Joan Higgins lead to the recommendations in the FIH final report (Federal Working Group, 2008) for the formation of the CNHC.

The CNHC, founded in 2008, reflects the regulatory body model presented in the White Paper on regulation of health professionals. It can be observed that initially the CNHC considered the FGW's plan for a regulatory body had some shortcomings, particularly in terms of professional involvement and wider regulatory best practice (CNHC 2008).

The CNHC creation and initial operation was funded by the Government, and has received approximately £800,000 funding from the Department of Health, between 2007 and 2011. Funding ceased in March 2011 (CNHC 2011a), and the CNHC is now self-funded, drawing from registration fees.

Hypnotherapy was one of the therapies the CNHC was established to regulate, with the profession specific register opening on 1st December 2010. Although initially founded with government money, the CNHC is a private limited company, managed by a Board of Directors, with four divisions: Federal Regulatory Council (FRC); Profession Specific Boards (PSB); Functional Boards; and Practice Advisory Panel (PAP), with a mix of lay people and practitioners (Federal Working Group, 2008) and the final decision-making authority resting with the FRC.

The CNHC indicate its key role is to 'act in the public interest and enable proper public accountability of the complementary therapists that is registers' with its key function 'to enhance public protection' which does reflect the original aims of the White Paper on

CAM regulation (House of Lords Science and Technology Committee, 2000). In terms of principles, the CNHC does appear to reflect the ideals of the White Paper on regulation of health professional (Great Britain, Secretary of State for Health, 2007) who initially influenced the Federal Working Group, listing values such as transparency and professionalism. This can be seen in the way it communicates its processes, and by consultation and communication with the professional associations. For example, it holds bi-annual meetings with representatives from Professional Associations (PAs) and then publicly displays the reports of those meetings on their website. At the last meeting, in November 2012, 35 complementary and natural healthcare associations (including hypnotherapy) were represented (CNHC, 2012b).

A criticism raised by some detractors of the CNHC is that even though the CNHC is a regulator, they themselves are unregulated by a higher or independent authority. However, the Council for Healthcare Regulatory Excellence (CHRE), who regulate the statutory regulators, will become involved in its regulation (CNHC, 2011b) with the development of 'Assured Voluntary Registers' (CNHC, 2011b). Still, at the May 2012 meeting with the PAs (CNHC, 2012c), it was confirmed that, following the passing of the Healthcare and Social Care Act 2012, the Council for Healthcare Regulatory Excellence (CHRE), will change its name to the Professional Standards Authority for Health and Social Care (PSA) during 2012. Furthermore, all healthcare regulation will sit under the PSA, so in addition to regulating statutory regulators, the PSA will set up a system of Accredited Voluntary Registers (AVR's) from 1st December 2012. The CNHC have indicated an intention to apply for AVR registration (CNHC, 2012b, 2013).

CNHC promote a primary aim of protection for the public and their website indicates a recommendation by the DoH, that where the CNHC registers the relevant complementary therapy, that individuals consult with someone who is CNHC registered. However, dissimilar to the professional bodies, there is no 'mandatory' requirement for membership and membership is voluntary. Also, unlike the professional bodies and their 'approved training', the CNHC appear to delegate some responsibility to their 'verifying organisations' to ensure that their members, who they 'verify', have appropriate qualifications according to their standards, which vary considerably, although it is perhaps early days since the launch of the Core Curriculum in late 2012.

In their most recent publication, launched in March 2013 (CNHC, 2013) reporting on their first five years in operation, the CNHC report their working with consumer and patient organisations to increase awareness of the quality mark and the CNHC registers. They also report working with a range of educational bodies, where training is provided in Higher and Further Education, and with professional associations where training is provided privately, such as for hypnotherapy. In addition, they indicate working with in excess of 70 professional associations and bodies as verifying organisations across the CAM sector.

Furthermore, the CNHC report working with NHS Palliative Care, with London Hospitals now requiring CNHC registration for practitioners, whether voluntary or paid. Thus, it would appear that CNHC is taking a diverse approach to awareness raising, beyond practitioners and extending to those organisations with which practitioners may interact or work for. Their work with the NHS has potential implications for the practice of hypnotherapy in the NHS and may have an effect on the medic/lay practitioner debate. If, as is presently apparent, ~~that~~ the NHS requires hypnotherapists to be CNHC registered, then their training must have met or be equivalent to the H.NOS and Core Curriculum. However, as discussed earlier, those medics who have undertaken training of a shorter duration and narrower content, and thus not meeting the H.NOS and Core Curriculum should not be permitted to use hypnotherapy within their role. This would protect the public from hypnotherapy treatment by a minimally trained (in hypnosis) medical practitioner and enable a more extensively trained hypnotherapist to be allowed to use hypnosis in a clinical environment.

The Professional Standards Authority

The Professional Standards Authority (PSA) state their aim is 'to promote the health, safety and well-being of users of health and social care services and the public' (Professional Standards Authority 2012a). Accountable to UK Parliament, the PSA oversee statutory bodies that regulate health and social care professionals. They also set standards for organisations who maintain voluntary registers for health and social care occupations, such as the CNHC. Registrants from voluntary regulatory bodies are able to join the PSA's Accredited Voluntary Register (AVR). The Professional Standards Authority (2012b) website indicates the necessary for the PSA to be self-funding and indicate an accreditation fee of £12,000 and an annual review fee of £9000. It can be

noted that the CNHC indicate they have budgeted for these costs (CNHC, 2012b) although at present membership rates (£55 for first therapy) and numbers (just over 5000) it would appear to represent in the region of 3% of gross income. Quite what value those on the AVR will gain from the membership is open to discussion. How the PSA acts in response to complaints would appear to differ from that of a regulatory body such as the CNHC as they state they will only accept complaints about an AVR registrant if it relates to a failing to meet the PSA accreditation standards. They indicate that a practitioner on an AVR with a complaint about their regulator should follow their organisation's policy and will not intervene in decisions made by AVR's relating to individual registrants complaints (Professional Standards Authority, 2012c). It can be of interest to note that the PSA website currently indicates having received interest in registering on the AVR from several hypnotherapy organisations. It can be questioned whether this would appear to indicate a lack of commitment or belief in the CNHC or even at attempt to bypass this form of regulation.

Alternative Regulators

Internet searches found two organisations, claiming to be CAM regulators, the validity of such claims being questioned on a range of forums and professional body/society websites. Both UK-based, the first, International Academy of Alternative Psychology and Therapy Complementary and Alternative Health Regulator (IAAPT) on their website 'camregulator.org' indicate they were the first voluntary regulator of CAM with their register in 2006, covering 127 CAM therapies. The register appears to have listings gained from other sources that are flagged as 'unclaimed' and individuals need to register to correct or update these details. The author has two 'unclaimed' entries on this site and neither are accurate (location errors). It can be noted that the IAAPT were mentioned in the CNHC Professional Association Meeting 23 May 2012 Meeting Notes (CNHC, 2012c), where it was reported that the CNHC had made contact with Trading Standards.

The other body is called the General Regulatory Council for Complementary Therapies (GRCCT). Although it currently claims (website viewed 28/12/12) to be the UK Federal Regulator for Complementary Therapies, this was not supported by perusal of the final report of the FWG (2008). Furthermore, it does not appear on the relevant regulatory websites, such as the CNHC, the professional bodies, such as the General

Hypnotherapy Register or the National Council for Hypnotherapy, nor the websites of training schools, such as the London College of Clinical Hypnosis, or the Surrey Institute of Clinical Hypnotherapy. However, it was mentioned as a source of registration by the British Council (2008:5) in their brief publication on Complementary Medicine.

At a CNHC meeting with professional association representatives in November 2009, Kate Ling, Head of European and Specialist Legislation from the Professional Standards branch of the DoH, who are responsible for the regulation of health and social care, confirmed that the CNHC is the *"only voluntary regulatory body for complementary healthcare which has official government backing"* (CNHC, 2009a).

In summary, although regulation is just one aspect of the White Paper on CAM regulation and other elements are discussed throughout this chapter, it can be considered that without regulation there would be little power or consequences for any standards, curriculum or codes of ethical conduct. The White Paper can be considered to have been highly influential in the development of hypnotherapy professionalism, with the drawing together of prominent societies, associations and individuals within the hypnotherapy field to assist in the formation of a voluntary regulatory body. There is also the focus on classification (Group 2 for hypnotherapy) which can be deemed a recognition of its present evidence base. A regulator which, with this professional unity, has been made aware of the needs and therapy specific aspects of the general hypnotherapy profession, as opposed to merely a single theoretical philosophy. Many of the professional associations and societies involved in the original discussion process, continue in their assistance to the voluntary regulator, the CNHC, as 'Verifying Organisations'. Furthermore, the NHS adoption of registration of the CNHC as the 'gold standard' has implications for all hypnotherapists wishing to and currently working within the NHS, whether employed or voluntary.

Verifying organisations and professional bodies

It would seem that almost every professional, industrial and commercial sector of the economy has its own guild or association these days. Most, according to Bennett (2010:73), seem to exist solely to make subscription money, offering little in the way or

support and information you cannot get elsewhere. They can claim membership offers professional credibility but it can be questioned whether the public recognises this.

The White Paper on CAM regulation (House of Lords Science and Technology Committee, 2000, s.6.5) refer to evidence provided to the committee indicating that training courses were often established before a relevant professional body existed and this was created subsequently. It was suggested that graduates from a particular institution often then started and operated a professional body for graduates from that training organisation, which may not yet be independent of that organisation, particularly where members are required to have graduated from a specific or group (accredited) of schools.

There are a range of professional societies and bodies accessible to either lay or medical hypnosis practitioners and these would appear to be divided into two 'camps'. There are those who consider hypnotherapists should be trained in another profession first, such as medicine, dentistry or nursing, and require members to be professionally qualified, such as BSCAH. There are also those who accept practitioners wishing to use hypnotherapy as a primary profession, such as the British Society of Clinical Hypnosis (BSCH).

However, adding to the medical / lay practitioner debate of section 2.3, in this chapter, is the membership criteria of some of the professional societies, such as BSCAH, which require members to be professionals 'in their own right'. They are required to use hypnosis only for the purposes for which they are professionally qualified. Furthermore, such members are required not to support the practice or teaching of hypnosis to those who are not eligible for their society's membership. Two such bodies are the International Society of Hypnosis (4.1 Code of Ethics) and the European Society of Hypnosis (4.1 Ethical Guidelines) and the British Society of Clinical and Academic hypnosis (4.1 Code of Ethics). All three societies are linked and appear to be mutually supportive of this prohibition.

Sitting between the two 'camps', some societies are focused towards the medical professions yet do not have such explicit exclusion criteria. The British Association of Medical Hypnosis is one such organisation (BAMH, 2012).

The other ‘camp’ can be considered to be the societies which believe that hypnosis is a therapy in its own right and thus do not require a prior professional qualification. Some predominantly accept members from specific training schools, such as the BSCH, who are linked to the LCCH. Whereas others, such as the British Institute of Hypnotherapy and Neuro-Linguistic Programming (BIH, 2012) and the General Hypnotherapy Register (GHR, 2012) accept members who fulfil a specific training criteria including number of training hours and do not specify particular trainers. Somewhere in-between are those organisations that accept applicants who have qualified with one of the society’s ‘approved’ training organisations. The Hypnotherapy Association UK only offer ‘associate membership’ to those who have trained at a school not on their approved list and ‘licentiate membership’ to those who have approved training (Hypnotherapy Association, 2012). It can be seen that this lack of consistency of approach supports the view of the White Paper on CAM regulation (2000, Summary II) identifying little agreement between professional bodies.

The White Paper on CAM regulation addressed the roles of professional bodies, as did the Budd and Mills (2000a) research into the current status of professional associations that found professional organisation of hypnotherapists to be complicated. They consider this is partly caused by an overlap with the organisations representing Psychotherapists, who do not consider themselves complementary or alternative and so were excluded from the survey. Mills and Budd identified seventeen bodies representing hypnotherapists, in an area where there is a wide variation of educational standards and practice, and consensus has been 'particularly elusive' (House of Lords. Science and Technology Committee, 2000:56).

As part of regulation and quality assurance, it is a recommendation of the White Paper for CAM Regulation (House of Lords. Science and Technology Committee, 2000, s.6.25) that professional bodies have an accreditation board for validation of training, so that whoever delivers treatments, whether a CAM professional or conventional health professional, has received training independently accredited by an appropriate regulatory body. Where training is provided at a university level, the universities should liaise when setting standards. The White Paper does not advise of a collective core curriculum and indicates there should be flexibility in how to educate practitioners (section 6.61), although it does suggest the all CAM students, thus including

hypnotherapy, should be taught the basics of anatomy and physiology. This would be supported by the British Medical Association (BMA) who considers all practices that claim therapeutic benefits should have a foundation in the basic medical sciences. Furthermore, the White paper suggests every CAM therapist have a clear awareness of the principles of evidence-based medicine and healthcare. Therefore, it would seem that all CAM therapists, whether medic or lay, should have a foundation of key knowledge, such as anatomy, physiology, pathology and psychology. Some CAM therapies that have City and Guilds validated training, such as Aromatherapy, already have basic requirements. However, as there is currently not a nationally recognised qualification for hypnotherapy, this further supports one of the recommendations of this study. Such a qualification should include these elements within the training.

The FWG report (2008:13) outline their views of the role of professional bodies suggesting they will serve an important role representing their members and developing their profession, neither, which fall under the CNHC's, remit. However, they will also work with the CNHC on matters relating to standards of proficiency, with the CNHC depending on their professional knowledge and expertise and attend periodic meetings and discussions. The FWG also consider professional bodies may develop their own core curriculum that meets or exceeds the agreed standards of proficiency.

Standards, NOS and curriculum

The White Paper on CAM regulation which indicates a need for consistent standards in CAM and the hypnotherapy sector has both H.NOS and a Core Curriculum.

Standards

The White Paper for CAM regulation (House of Lords Science and Technology Committee, 2000, s.6.1) documents that the need for high quality accredited training is vital in protecting the public from incompetent and dangerous practitioners. In considering the evidence received by the Committee, they indicate CAM training courses vary between and within the same discipline, in content, depth and duration as has been discussed earlier in this chapter (such as section 2.5).

Furthermore, the White Paper (House of Lords Science and Technology Committee, 2000, s.5.83) recommends that healthcare practitioners who use CAM within their

healthcare role are trained to the comparable standards of lay practitioners. The White Paper also raises concerns about the lack of communication between the lay and medical bodies. Furthermore, it considers the non-medical professional regulatory bodies should continue to be responsible for the educational standards of the professional they regulate (section 5.22). There could be seen to be an expectation that such regulators will collaborate with the Sector Skills Council for Health.

The FWG (2008:9) discussed at length matters relating to standards of proficiency. Whilst these are central to gaining and remaining on the CNHC register, they recognise that an individual's practice will develop over time. However, they may become more focused and specialised in a particular field, which may result in them being unable to demonstrate meeting all of the standards that apply to their profession. The report considered, in these cases, that where an individual remains within the scope of their practice and makes efforts to stay updated generally, this would be satisfactory, although they would need to undertake training if necessary should they wish to move outside of their current scope of practice.

Skills for Health, NOS, and the UKCES

An agency established in April 2002, (Skills for Health, 2012b), Skills for Health is tasked by the government to develop a range of NOS in healthcare disciples to de develop solutions for a skilled workforce to meet the needs of employers (British Council, 2008). One such NOS is the H.NOS initially launched in 2002. A recent review by the National Audit office (Skills for Health, 2009:3), indicated they were regarded as 'outstanding' in their contribution to workforce design, and they were re-licensed in 2009 (GRCCT, 2012). Skills for Health are currently working to the strategic plan that covers the period 2010 to 2015. Their strategic plan includes an increased focus on public health and prevention of ill health (point 2.2). Skills for Health is one of 25 Sector Skills Councils who are the responsibility of the UK Commission for Employment and Skills (UKCES).

The White Paper for CAM regulation makes clear a view that the setting of standards is an important element in public protection from poorly trained practitioners. Furthermore, it specifies (House of Lords. Science and Technology Committee, 2000, s.6.63) the DoH and Government's position that a precondition of any professional

register must be that recognised standards are met, regarding this as a fundamental aspect of professional regulation. The White Paper goes on to recognise CAM professions are fragmented and that an external body could work together with the individual CAM bodies to achieve core-training standards for each therapeutic discipline. Skills for Health have worked with a number of stakeholders in the hypnotherapy profession to gain 'profession-specific' information that contributed to the formation of the initial H.NOS.

The National Occupational Standards (NOS) are described by Skills for Health as indicating how best practice can be achieved by detailing what a competent person should be able to do to conduct a specific activity or function in terms of what an individual needs to be able to do, know and understand to a nationally recognised level of competence. Furthermore, they address the key activities within the occupation under all the circumstances the individual is likely to encounter. Although this latter part of the description is supported by the UKCES, it can be questioned how accurately this reflects hypnotherapy practice. It could be considered that the NOS in their present format are somewhat broad and unlikely to address every situation. It could also be said that the NOS are too narrow, in that they do not specify the extent to which persons should hold knowledge and understanding nor demonstrate ability and skill.

Skills for Health suggest the NOS are tools for the benefit of individuals (clients and therapists in this case), together with organisations (potentially employers or professional bodies) and training providers. The NOS are considered to describe a minimum standard and determine competence as well as provide a framework for training and development that can form the basis of a Vocational Qualification on the Qualification and Credit Framework (QCF). Skills for Health further consider employers may benefit from NOS for benchmarking, easing recruitment and workforce planning and improve quality of service. For employees or therapists, they are said to offer a structure against which they can measure performance and thus identify development needs. Furthermore, they could be used to aid gathering of evidence to support a qualification within the health sector. They can be of particular benefit to educators, forming the basis of qualifications and identifying gaps in provision thus providing well-balanced training. In addition, Skills for Health indicate the NOS are mapped against the NHS Knowledge and Skills (KSF) framework (Skills for Health,

2012a). However, it was not possible to find how hypnotherapy (and the H.NOS) fits into this framework.

More recent than the H.NOS, the Digest of NOS for Psychological Therapies reports that the government commissioned Skills for Health to work with a group of academics and professional therapists to develop NOS which are 'practice oriented' for Cognitive and Behavioural Therapy, Psychoanalytic/psychodynamic psychotherapy, Family and Systemic Therapy and Humanistic Therapy. Fonagy (2010) suggests defining what generally happens in psychological therapies can contribute towards dispelling the mystique and suspicions formed from prejudice. Furthermore, Fonagy considers that such transparency and openness will not adverse affect 'the magic of interpersonal creativity which remains at the heart of the art of psychological therapy'. However, Fonagy (2010) indicates that whilst the NOS are important for good practice, they are not sufficient for good practice, although he considers they do create a clearer discourse about psychological therapies. Mace (in Fonagy, 2010) considers the NOS are helpful in training course design, suggesting they provide a map against which a curriculum can be compared.

UKCES Strategic Objectives in 2012/2013 (UKCES, 2012a, b) include generating employer investment in skills and driving a competitive skills base. UKCES conduct UK-wide employer skills surveys (UKCES, 2012c) and look at developing occupational skills policy (UKCES, 2012d) for the workplace (UKCES, 2012e) and the self-employed (UKCES, 2012f). They also conduct Sector Skills Assessments to gain understanding of the skills priorities within different sectors of the economy, including health (UKCES, 2012g). The most recent Sector Skills Assessment for Health was published on 7th November 2012 (UKCES, 2012h). This report further highlighted their aim to maximise the influence of skills policies to secure an internationally competitive skills base. Also of interest is a summary of information from the Labour Force Survey 2010 by the Office of National Statistics. The chart in that report indicated that 34% of the UK have qualifications at National Qualifications Framework (NQF) level four or above, and when looking specifically at the health sector this rises to 59%. It can be considered that hypnosis training will range from NQF level two to level three or four for practitioners. The combination of all three levels accounts for 82% of those in the health sector and 72% as a nation. Furthermore, the report indicates those holding NQF

level four or above has increased from 42% in 2002 to 59% in 2010. This increase of 17% is greater than the UK national increase from 28% in 2002 rising by a further 9% to 37% in 2010. This would appear to indicate a higher than national average of education in the health sector.

The UKCES look at pertinent issues surrounding the relevant sectors, recently looking at occupational regulation and its influence (UKCES, 2012i) including Standard Occupational Classifications 2000, which has 9 major groups including '2' professional occupations, '3' associate professional and technical occupations. The Standard Occupational Classifications (SOC) were introduced in 1990 and are maintained by the Occupational Information Unit of the Office for National Statistics. The SOC aim to classify all paid jobs in the UK and group them according to 'skill level and specialisation'. Skill level is determined by the length of time necessary for a person to become fully competent to perform their job, taking into consideration formal training and any necessary experience for competence to become acquired. There are four skill levels, the first is at completion of general education level, the second level indicates a longer period of work related training, and the third requires a body of knowledge up to degree level or lengthy vocation training, potentially with a significant amount of work experience. The fourth skills level is termed as 'professional' and normally requires a degree of equivalent period of work experience. The other component, skill specialisation, being regarded as the field of knowledge required for competent conduct (Office for National Statistics, 2000a). It could be considered that with general hypnotherapy training being provided at level three, with the introduction of the MSc. in Clinical Hypnotherapy by the University of West London (of at least four academic years in duration) that this may herald a clearer transition into perceptions of level four and professionalism. It can be noted that a survey by Long et al (2001) found no obvious correlation between length of training and treatment cost, which could indicate that shorter training may suggest better value for trainee practitioners. Although shorter training may have sufficient transfer of knowledge, it might lack development of expertise that comes over time or the development of analysis, synthesis and integration.

The present SOC classification, last revised in 2000 indicates that health professionals (such as medical practitioners, dental practitioners) are categorised as Group 2, level 4

and health and social welfare associate professionals as Group 3, level 3, such as osteopath, psychotherapist and hypnotherapist (SOC Ref. 3229) and hypnotist entertainer (SOC Ref.3413). This can be considered positive that from a professionalism perspective, a hypnotherapist achieves a similar level to other, albeit physical, therapists. Yet, this also suggests clearly that hypnotherapists are not considered to be at the same level as medics.

A more directly-focused of the UKCES has been to consider the NOS (UKCES, 2012j) and relevant employer case studies (UKCES, 2012k, 2012l) and the NOS Strategy (UKCES, 2012m) resulting in the NOS strategy 2010-2020, the NOS quality criteria, and a guide to developing NOS. This is perhaps an indication of the depth and reach of the NOS.

The General Hypnotherapy Register advise members that the current NOS have been revised by Skills for Health (General Hypnotherapy Register, 2013). Of the four documents : CNH1 'explore and establish the client's needs'(Appendix A2), CNH2 'develop and agree plans' (Appendix A3), and the 'Principles of Good Practice' (Appendix A4) are generic documents and relate to all complementary therapies. Only CNH3 'provide hypnotherapy to clients' (Appendix A5) is discipline specific.

The first NOS, CNH1, has five general performance outcomes: evaluating requests, provide an appropriate environment, discussing the client's expectations, discuss the client's needs and evaluate the information obtained. It can be seen how these general criteria can relate to a wide range of therapies, yet still offer a hypnotherapist clear guiding principles. The second NOS, CNH2, is also broad in its performance outcomes, with two key criteria of explaining the available options and discussing the approach to be taken. These are supplemented by a separate guide to good practice. Whilst CNH1 and CNH2 are focused on interactions with a client, prior to treatment actually commencing, the good practice principles are broader in their requirements, although they do refer to client practice, such as working with sensitivity (no.9), respect for the client's dignity (no.4) communicating clearly (no.8), having regard for safety (no.5) and working within the scope of their practice (no.11). Some principles are also knowledge related, in that they understanding the philosophy and principles of their discipline (no.2) and the current legislation and policy that applies to their discipline (no.3). These

principles also introduce the concepts of reflective practice (no.6) and critical evaluation of the professional knowledge (no.10) topics rarely covered explicitly on some hypnotherapy training courses.

The need for regular and appropriate formal supervision (no.1), which can facilitate reflection, is a concept that hypnotherapists may have yet to adopt and there are few formal organised structures for doing so, although some professional bodies, such as the British Society of Clinical Hypnosis maintain registers. Until regulatory bodies, such as the CNHC require evidence of supervision in order to renew registration, there is little incentive for some hypnotherapists to engage in the process. Some hypnotherapists are opposed to clinical supervision. Gilbert, in an article published on the James Braid Society website (Gilbert, 2006) suggests that the supervision model is counter-productive and should be discarded, suggesting instead the use of 'resource networks'. He suggests that instead of supervision being a professional action it undermines the therapist and suggests therapists 'have all the resources you need to help your clients', further suggesting therapists will only learn by using their resources. There are strong arguments against Gilbert, from practical, safety and ethical perspectives and it is to be hoped that the principles of good practice, forming a guide for the core curriculum, become an established part of training and thus new therapists understand the values of such formal reflection of their work. The remaining item listed under the principles is 'an awareness of their own and others emotions state and responses' (no.7). It could be suggested that this is also rarely explored explicitly during training, or CPD, or in the literature. However, this may now be explored both by reflective practice and supervision.

The final NOS, CNH23, on providing hypnotherapy to clients, has 6 performance outcomes: selection of methodologies; client awareness aware of their role; aftercare advice; applying appropriate interventions; evaluation of the outcomes and accurately record information. Whilst later outcomes are somewhat general, the first outcome, relating to selection of methodologies, is explicit in the 8 sub-sections, particularly relating to the specifics of trance, consciousness, approaches, suggestions and relationships between methodologies. Whilst individuals attending training which is broad and comprehensive will be able to meet these outcomes, those attending briefer or more narrow training may only learn some perspectives and not sufficient to meet these

criteria. Thus having this NOS mapped against its associated Core Curriculum is beneficial to those who are exploring training options. Training that meets the Core Curriculum will be mapped against the CNH23 performance outcomes. It can be noted that when the H.NOS are referred to in this thesis, and the questionnaires, that 'H.NOS' refers to all four of the separate H.NOS documents.

Curriculum

Curriculum may be described as the underlying principles of the approach to teaching and learning, such as for 'competency-based curriculum'. It can refer to the overall content of what is to be taught. Furthermore, it can also cover both of these and refer to the whole teaching of what, how and why. Atherton (2011a) suggests there are distinct conceptualisations associated with curriculum: the extent between vocational/ professional and academic and the scope between mastery/induction and developmental/constructive.

The vocational / professional emphasis is on using the training to be able to do something else. Atherton (2011) suggests education becomes training when the background is less important, for example, counsellors are often trained without awareness of the dubious content of some of their psychology (from a scientific perspective). With an academic focus, the material is considered important in its own right, such as the learning of history. This can be associated with the lower aspects of the cognitive domain in Bloom's taxonomy (see section 2.12 T.A.P. model) whereas the 'use' in vocational may be more related to 'application' in Bloom's higher level. However, 'academic' also related to the complex affective domain and is generally higher regarded in society to vocational study. A degree may be better perceived than a comparable level five or level six National Vocational Qualification (NVQ).

Mastery / induction approaches to curriculum relates to training to 'induct' an individual into an established body of knowledge, such as the range of established hypnotherapeutic theories and applications. Atherton (2011a) suggests that vocational competence-based curricula can be based on this model when it is known what performance criteria constitutes evidence for competence. It could be suggested that mastery in hypnotherapy comes at different times as students master the basic techniques and then start to learn more advanced and complex approaches. The

developmental / constructive type of curriculum can be associated more with advanced skills, as opposed to simple knowledge, developing a more highly developed skill, thus improving, as opposed to reaching a specified point.

The topic may direct how the trainer designs the curriculum, with several combinations that have relevance for the teaching of hypnosis. A vocational-mastery focus will result in a standardised curriculum, with clearly formulated objectives, following a systematic approach to a defined level of competence**.** Thus, this relates more to initial training, where students need to be able to induce hypnosis and work safely. However, the vocational-developmental teacher may have less defined objectives as they use interaction techniques such as group work and open discursive activities to develop more experienced practitioners, such as those engaged in CPD or advanced training. A teacher more commonly working with school age education, may employ the academic-induction approach where knowledge is transmitted, and assessment is based upon 'correct' answers. This may be useful for factual supportive information, such as learning the legislation relevant to hypnotherapy practice and other topics that are not open to much interpretation. In contrast, the academic-constructive approach is the often the most highly individualised. This can be associated to the types of training where the student has choice as to which modules or directions they take.

When considering Atherton's summary diagram (Figure 2.1) it could be said that hypnotherapy training curriculum which meets H.NOS most relates to the 'Competence' sector, whereas the current MSc. Clinical Hypnosis may more relate to the 'University education' sector. Those qualified practitioners who have engaged in CPD relate neatly to that corresponding sector (Vocational – developmental/ constructive). What may be most interesting and a phenomena widely acknowledged in the USA and an area of hypnosis practice gaining more awareness in the UK, is that of the 'hobbyist', someone who learns and use hypnosis predominantly for their own pleasure or entertainment. This fits neatly to Atherton's final sector, those who learn 'for the love of it'. Given the diverse nature and needs of those engaging in hypnosis and hypnotherapy training, a hypnotherapy curriculum that covers all aspects of Atherton's model has the potential to address the broad agendas of those being trained.

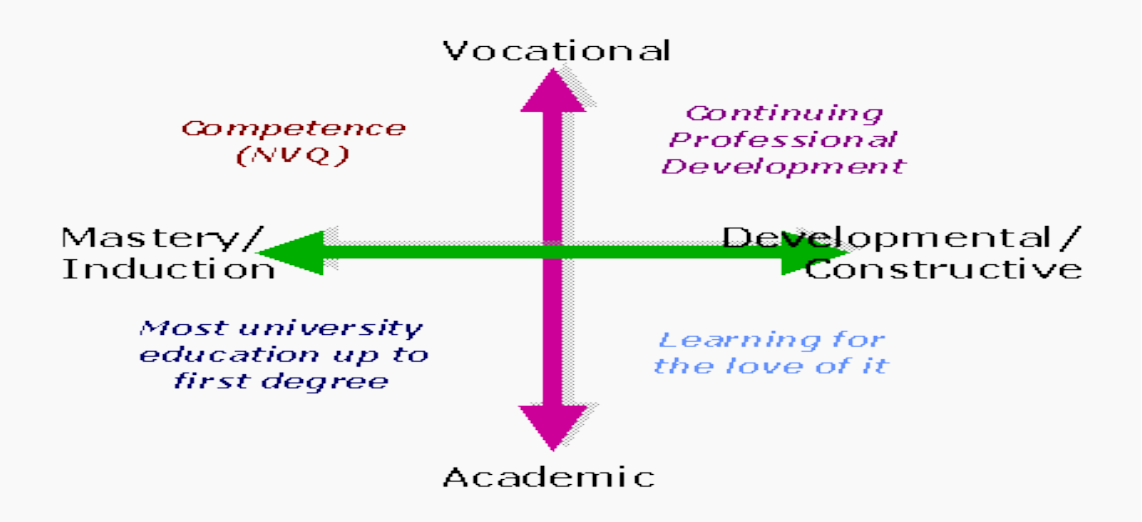

Figure 2.1: Atherton's approaches to Curriculum (Atherton 2011a)

Hypnotherapy Core Curriculum

Elkins and Hammond (1998) have long suggested the need for an accepted standard curriculum in clinical hypnosis.

The White Paper on CAM regulation (House of Lords Science and Technology Committee, 2000, s.583) encouraged both lay and medical bodies representing CAM therapists to collaborate more on developing core curricula, indicating a view that it was important for both lay therapists and medical practitioners to be trained to the same skill level in that therapy. Currently, it would seem, from the training syllabus on the BSCAH website that those undergoing the initial training for medical personnel are receiving less training. The White Paper suggests sharing knowledge and training resources would benefit both groups.

Several organisations have already developed core curricula. The UK Confederation of Hypnotherapy Organisations (UKCHO) Hypnotherapy Schools Sub-Committee had developed a core curriculum and guidance for a minimum of 120 hours classroom and 450 total study hours. This is a guide also published on the present Core Curriculum. It is interesting to note this figure exceeds the minimum training suggested by Hunter (1998:33) who reported that in Indiana USA, it was considered that 350 hours training was to be the acceptable minimum. It is interesting to note that neither the UK Core

Curriculum hours' requirement, nor the Indiana training hours' requirement, indicate how this figure was reached.

Some training organisations will have had to extend their training to meet this, whilst others already exceed it. Interestingly, Simons *et al*. (2007:267) reported that BSCAH have a core curriculum for training, yet their current initial training (in their new format as the British Society of Clinical and Academic Hypnosis) only extends to three weekends of face-to-face training. The most recent newsletter (No.20) reports that the CNHC Hypnotherapy Profession Specific Board (PSB) will advise on standards of education and training and learning outcomes supported by learning outcomes based on the H.NOS. Such learning outcomes will be supported by the core curriculum, for training offered by hypnotherapy training schools and organisations.

A core curriculum for hypnotherapy training schools and trainers was agreed by the Hypnotherapy Regulatory Forum in February 2011 and is displayed on the websites of many professional associations such as the GHSC (2011) and the British Association of Therapeutic Hypnotists and NLP Practitioners (2013).

The CNHC Profession Specific Board's role was to liaise with the specific therapy professions to develop a core curriculum. Presently, according to the CNHC November 2012 meeting (CNHC, 2012b) although the CNHC have received core curriculum information from all registered disciplines, in several instances they exceed the regulatory requirements. Thus CNHC will be considering whether any revisions are required. The CNHC do have a Core Curriculum Template (CNHC, 2012d) for professional associations to develop. It would seem that as the core curriculum for hypnotherapy is already adopted by many professional associations that the CNHC are most likely to have accepted this in its present form as acceptable until its scheduled review date of February 2014.

Hypnosis education and training

Hypnosis and hypnotherapy education in the UK is diverse, ranging from online and distance learning training and simple workshops, through to a MSc. in Clinical Hypnosis. However, there are no specific guidelines on how to teach hypnosis, nor what influences learning and knowledge, and whether duration and extent of training is

significant and these key issues are discussed in the section that follows. The value of practice during training is also discussed, together with the use of Continuing Professional Development (CPD) and the potential merits of accreditation of training.

Hypnosis education

Hypnosis education is a broad topic and there are many training options available to a prospective student, with a range of literature and journals providing factual information and a plethora of training schools with a wide range of teaching and learning approaches and what constitutes knowledge. This section also considers the practical application of hypnosis with practice, professional development and the issues around verification of training.

Havens (2003:169) suggests that before hypnotherapists can learn how to hypnotise they must first develop some comprehension of what hypnosis is, although as can be seen in the 'Definitions' section, this is still under debate. At the start of an introduction course to hypnosis, it can be surprising to find that many of the students have never experienced hypnosis before, yet they have committed their time and finances to its study. Whilst this can mean that they will not have been exposed to poor practice, it also means they have no concept of good practice and what to aspire to in developing their expertise.

Silver and McGill (2001:25) suggest the qualifications of a hypnotist are first of all confidence, a strong will and the desire and knowledge to use both, whereas Sommer (1992:11) reflects that Milton Erickson considered that in any work where an individual is going to influence they had better know what they are saying.

There are no widely accepted 'standard' qualifications in hypnotherapy in the UK (British Council, 2008:3). Training varies greatly, from online e-books and correspondence courses, to courses with sound professional and academic backgrounds, and even a MSc. in Clinical Hypnotherapy. A survey conducted by Fellows (1996) of 65 British university psychology departments reported that 11 undertook research in hypnosis and some offered a variety of lectures, but none offered a full course, despite 80% stating that hypnosis was a suitable subject to teach. There is a lack of current

research data giving the most up to date position regarding hypnosis inclusion in lectures. This could be an area for future research.

A search on EBay (an online store), on 2nd January 2013, found several training options and it is possible to pay a small amount and receive a e-course or DVDs and several impressive-looking certificates, although Brown (2006:174) advises a caution with many downloadable courses.

A popular starting place and a readily accessible source for professional development is the use of literature. A search on Amazon UK (January 2013) found 5972 books under 'hypnosis' and 1671 books under 'hypnotherapy. Their Kindle store had 1175 'hypnosis' e-books and 405 'hypnotherapy' e-books. These would seem to be increasing rapidly, as a further search on 27th November 2012 found 5830 'hypnosis' books. It would seem then that there is an easily accessible and vast supply and wide demand for books relating to hypnotherapy, whether at the 'popular' end of the spectrum or at the 'academic' or research end.

Somewhat less accessible are professional and academic journals. Members of the medical hypnosis association BSCAH have access to Contemporary Hypnosis Journal and now so do members of the BSCH, a lay hypnosis association. Other associations may have benefits but these appear less well advertised. Access to International Journals such as those of the American and Australian Clinical Hypnosis Associations are less accessible, even to those engaged in academic study with access to Science Direct or MyAthens. Thus journals are less accessible, predominantly to lay hypnotherapists and most accessible to researchers. It could be a positive benefit in the future for associations to provide members with at least a summary of what each volume contains. This could, over time, develop an academic and research awareness in members and contribute to positively influencing the knowledge base of the professionalism.

Finding a training school is not easy, with little to guide the prospective student. One well-known Further Education college, Morley College in London, is providing evening classes to practitioner level (National Guild of Hypnotists Certified Hypnotherapist course) and one University (University of West London in partnership (providing

accreditation) with LCCH (a private college) is offering a MSc. in Clinical Hypnotherapy. Generally though, the training is provided in the private sector (Hewitt, 2005). This means that for many potential students, they have to do their research, consider their needs and resources, and, for some, take a chance or gamble that they have made a well-informed decision. There may be little correlation between course cost and quality, and thus a mistake could be an expensive one.

A simple web search for 'hypnosis training' or for 'hypnotherapy training' can bring up a multitude of options and for the uninformed it can be difficult to know which are reputable and which not. The bias or 'angle' of a website is also not always easy to determine. The website 'Hypnosis Training UK' appears to offer information about hypnosis and hypnotherapy training, with general information, types of qualifications, societies, courses and a variety of links. The contact us page refers visitors to a Google-mail address, thus it is not transparent which individual or organisation authored the information on the site. It would appear though that the site attempts to offer a balanced perspective, covering both lay and medical approaches and views.

The White Paper for CAM regulation (House of Lords Science and Technology Committee, 2000, Summary IX, Chapter 6) indicates that CAM training courses are considered unacceptable in their variation of duration, depth and content. It suggests that to ensure any CAM practitioner is well trained, there is a need for a partnership between Higher Education and regulated professions, with validation and accreditation to protect the public from incompetent practitioners. It is interesting to note the requirement specified is for Higher Education. This could be perceived as more professional, than Further Education, which is more often associated with vocational learning. However, whilst it could be argued that statutory regulation would give the perception of professionalism, there exists, in the UK, a higher esteem generally for academic qualifications.

It is suggested that wherever the training is provided, several other aspects may be more significant, 'who' is taught with 'what' information, 'how' it is taught and by 'whom'. From preliminary investigations, few courses seek references or have entrance criteria to entry-level hypnotherapy training. Those courses that offer CPD training also rarely seem to check the practitioners' qualifications are valid. Of more concern than

academic demonstrations of learning, may be the extent of basic skills, such as communication, empathy and comprehension, as well as the motivation to learn. All of which contribute to teaching and learning.

How people teach

There are no specific UK-wide recognised hypnotherapy teaching qualifications. Only in Further Education is there specific legislation relating to teaching qualifications in general. If, for example, hypnotherapy is taught in a Further Education college, then a minimum of a Preliminary Teaching in the Lifelong Learning Sector (PTLLS) certificate is required by legislation, the Further Education Teaching Qualifications (England) Regulations 2007. In Higher Education, many universities expect a Masters degree as a minimum in a relevant subject, together with a Post-Graduate Certificate in Education or Fellowship of the Higher Education Academy. Furthermore, depending on the level to which they are teaching, some universities expect staff to have achieved a PhD or equivalent, or at least be working towards that. However, this can vary from institution to institution as to qualifications and experience.

Kinchington and Goddard (2006:211) suggest the conventional perspective of a teacher has been as a 'font of all knowledge'. Expanding on this, Calderhead (1987) suggests there needs to be both subject knowledge and teacher knowledge. However, Burgess, *et al.* (2006) suggest teachers have several types of knowledge which constantly change, in subtle ways of which they may not even be aware. Yet they are expected to have a sound discipline knowledge (Scott *et al.* 2004) and to appreciate how that understanding shapes their approaches to learning and teaching (Burgess *et al*. 2006).

There are few guidelines for universities and colleges as to a minimum standard for hypnosis or hypnotherapy teachers. It could be suggested that such a standard would include recognised initial training, advanced post-qualification training, teacher training and practice experience of at least two to five years. Hunter (2000) supports this view although considers 2-3 years full time practice as a minimum. Without this, a practitioner is unlikely to be able to respond fully to a wide range of student questions, nor provide relevant case histories to support teaching examples. Furthermore, such a level of advanced theory and practice experience would reduce the risk of a student with psychological disturbance going un-noticed. Such a 'minimum' criteria could be

adopted by the private sector or by the entire hypnotherapy training profession, ensuring perhaps a minimum standard of teaching knowledge and skills wherever they learn.

Unfortunately, perhaps, in the private sector, it would appear teaching requirements are less specific. Whilst there are qualifications for teachers to become Neuro-Linguistic Programming (NLP) trainers, there are few organisations who offer 'teacher training' for hypnotists or hypnotherapists. One such international course is a 5-day course provided by the National Guild of Hypnotists (NGH), the oldest and reportedly largest hypnosis organisation in the world, which offers a 'Certified Instructor' (CI) course for experienced and suitably qualified practitioners. The course addresses both teaching approaches and hypnotherapy content of the NGH certification course. The CIs receive support from the NGH directly and via CI forums and are permitted to teach and examine the NGH certification course. This ensures a consistent standard of teaching content.

Some hypnotherapists clearly appear to feel they have something to share with others (Burton, 2007) and go on to teach, whether in workshops, by writing books, or going on to form their own theoretical paradigms (such as Erickson) or their own teaching schools.

It can be accepted, as with any teaching, that each hypnotherapist will have his or her own teaching style or approach. Jonathan Chase, during the researchers' attendance at several of his workshops, has said that he "uses hypnosis to teach hypnosis". Milton Erickson, is well known for using 'teaching tales (Rosen, 1991:15; Erickson and Keeney, 2006) and Owens (2006) suggests stories teach through their 'knots of relevance'. However, Kroger (1977:391) does make a strong case when he suggests such stories and cases reported are usually only the successful ones, yet whilst reluctance to use failures is understandable, he considers they are just as valuable a teaching aid. It could be argued that the benefits from such are two-fold. Not only can students learn what went wrong, they can gain a more realistic perception of the true nature of hypnotherapy and realise early on that not everything will work as expected all of the time. If presented as a learning experience it could allay the fears that a hypnotherapist might have about a loss of prestige or authority.

The teacher's role during training can be considered as crucial (Buchanan and Hughes, 2000:98), together with the approach that they take, as well as their personal influences (Hall, 1989) and views on what constitutes teaching as this will inform the material presented and the methods of presentation. An example being Morgan (1996: 202) who considers teaching has connections with systems of human knowledge, interaction and communication. Bandler (1985:119) is perhaps somewhat critical of how teachers approach teaching, suggesting they are often taught how to memorise.

Learning

From a behavioural perspective, learning is about absorbing new material and incorporating it into the self, which may require a degree of exertion (Bender, 2001), while using what has been learned requires a different set of behaviours (Charvet, 1997). It would seem that the views of Wartik and Carlson-Finnerty (1993:23-32) agree with the behavioural perspective, considering the effects of habituation and conditioning. Teaching, learning and knowing 'must mean more' according to Bandler (1993:1) who suggests to make it worth having, to do more. Brown suggests hypnosis is best discovered by a individual with serious interest who is prepared to study (Brown, 2006:174). Hypnosis and hypnotherapy are complex blends of theory and practice. Ready and Burton (2004:284) suggest the learning process involves many rich components beyond just being taught facts or giving the right answers. They suggest people need to be put into a good positive and receptive state to learn in order for learning to connect and endure.

It could be suggested that the view of Ready and Burton is that of an external locus of control (Rotter, 1954) where others are influencing the individual, which is how some people are motivated. According Biddle and Brookhouse (2005) some are motivated by extrinsic motivation (p.24), whilst other learners may have more intrinsic motivation (p.22), motivated by the learning itself. In addition to motivation and the actions of others, Reisberg (2001) suggests the role of intent to learn is a factor for knowledge entering long-term storage. Trudeau (2005:5) considers it from a 'teachability index' perspective, with two components: willingness to learn and willingness to accept change.

It could be agreed by many that the theory and practical factors within hypnosis are related to knowledge and skill. Markham (1991:23) considers hypnosis is an acquired skill, which is not hard to learn, with the skill actually located in the application of the techniques, although, according to Walker (2005:3) "everyone can learn new skills". Walton (2000:166) considers there to be a four-step process for the development and raising of a skill proficiency, with demonstration and explanation of concepts and theories to new learner, followed by study, practice, use. Walker (2005) further suggests skills are a combination of particular habits of thought, action and attitude, linked together in a particular sequence to produce a desired result although Walton (2000:112) suggests individuals reacts to the events that occur in their world in two key ways, emotionally and mentally (cognitively) and certainly Buzan (2007) considers vocabulary plays a vital role in learning and remembering. How such information is presented can be indicative of how the material will be absorbed and retained. Thus there is a significance to presentation of material which goes beyond 'what' is presented to 'how' it is presented.

Knowledge

Knowledge can relate to what the professional knows about their subject, which incorporates both the 'knowing that' and 'knowing how' (Calderhead, 1987). However, Burgess *et al*. (2006) indicate concepts of knowledge and understanding are problematic which knowledge changing in such subtle ways that individuals may not even be aware of the change. Loughran *et al*. (2003) suggest it is difficult to document teacher knowledge as it is closely associated with seeing knowledge in practice and practice is regarded as something related to skills. Furthermore, Royle (2006:24) suggests some factors are more relevant to hypnosis than others, indicating his view that knowledge is measured by depth. As a professional, they will have developed their own theories (Schön, 1987) together with knowledge and understanding about their own area of work.

Extent of training

Nothing can be further from the truth that the hypnotist (or hypnotherapist) must possess some mysterious power, Van Pelt *et al*. (1953) suggest the power lies within the patient and is their imagination. All that is required of the hypnotist to induce a trance is the technical knowledge of how to master this power. The technique of hypnotism is

so simple that practically anyone can master it with ease (p.17), but mere induction is not hypnotherapy, it is suggestion that creates change. Although Elman (1970) suggests some can underestimate the extent of training needed, writing, "I *have been teaching hypnosis to medical men for years and have found that many of them seem to think they can become expert hypnotists after a few classroom and practice sessions"*. However, Hartman (2000) considers hypnosis training for a licensed counsellor need only be 24 hours to start with. Further adding to the lay therapist / medical practitioner debate, some, such as Batttino and South (2006:528) recommend restricting training to healthcare professionals, furthermore specifying that they should have either Masters or Doctoral degrees and that undergraduates should not be taught. This view is supported by Simons *et al*. (2007:264) who propose that training should only be undertaken by individuals who already possess the professional qualifications, and experience, in understanding, and treating, those problems for which they intend using hypnosis. However, it could be questioned whether a General Practitioner would find it relevant to work with sport performance enhancement or simple nail biting, or even would have the time to commit to treating it. It could be questioned whether this is the best use of their extensive medical training and resources and considering the annual salary of a General Practitioner, it certainly can be questioned whether such treatment would be the best use of their time from a cost perspective. A hypnotherapist could be better value on a 'pound per minute' analysis. Then again, Rossi (1980:22) regards the physician who learns hypnosis as one who learns how and when and why to give suggestions, and by training is taking a postgraduate course in how to suggest to patients attitudes, understandings and behaviours enabling them to adjust more adequately to life. Thus such training would influence all their interpersonal interactions. Furthermore, where medical personnel become trainers, such as Andrew T. Austin, a registered nurse (Austin, 2007) they can offer an added dimension to the teaching of hypnosis. Slater (1958:13) certainly values the widest possible experience and understanding.

Mills (1996:48) suggests that professional bodies, such as the NMC previously mentioned, are stating that increased professional training is necessary to provide safe practice in the public interest. It has been reported that it is difficult to determine the precise extent of training and a lack of sufficiently precise instruction material (Gibbons, 2000). This is supported by Mills (1996:49) who considers the extent to which competence is provided in complementary healthcare training establishments is

often impossible for an outsider to judge, whether they are considering the specifics of learning about the conscious and unconscious mind (Eason, 2006:13), or the view, of some, that hypnosis training is needed to be good at mind control (Ellis, 2006:33).

The value of learning 'by book' is questioned by Westbrook *et al*. (2008), who suggest that good therapy cannot be learned easily, or quickly, from a book. This is supported by Hartman (2000) who states he has a bookcase of books that are wonderful, but do not really make much sense. It could be suggested that this is an indication that whilst books are a useful starting point, practice and experience may not come from books.

Several authors explore professional and personal responsibility within their books. Chase (2007:18) advises that responsibility lies with the individual who experiments with the approaches described in the book. Bandler and Grinder (1982:204) also advise caution as protection to reader and those around them. This may be highly appropriate as Berne (1971:300) considers most popular books on hypnotism are highly misleading, although this may partly be due to the style of writing which Ellerton considers need to be approached from different perspectives to suit different audiences (Ellerton, 2006). It may be that precautions are needed to be most explicit in the books at introductory level as there are many 'introduction to hypnosis books' offering a 'step-by-step' guide (Hewitt, 1970), a Dummies guide (Bryant and Mabbutt, 2006) even 'how-to' for stage hypnotists (Ronning, 2008) openly available to all.

Whilst many hypnosis books are written in the format of 'textbook', some appear to be the result of 'in-person' training events and case studies (Hall and Bodenhamer, 2005:57) or as a transcript from a workbook (O'Hanlon and Martin, 1992). Some books are focused on a particular paradigm, such as Ericksonian (Havens and Walters, 2002:3). Other books offer advanced techniques, perhaps suggest they are a guide for teachers (Watts, 2005), or have evolved into one (Webb, 2005), as a distillation of learning and thousands of hours of practice (McKenna, 2006) aimed towards advanced practice and teaching 'sophisticated procedures' (Watkins and Barabasz, 2008:1). These can be aimed at professionals (Cerbone 2007), to help them work at deeper levels (James, Flores and Schober, 2006), and combining the practical with the scientific (Mc Gill 2004:3). Some authors even report incorporating hypnosis into their writing style (Overdurf and Silverthorn, 1995).

Although some books specify they are for clinicians (Nejad and Volney, 2008), some are aimed specifically towards therapists (Silverster, 2006). Here differences in initial training may lead to gaps in knowledge, although the authors may take it for granted the reader is familiar with the general literature in that field (Gill and Brenman, 1961).

The value of practice

McGill (2004:3) asserts that the importance of practice in hypnotising cannot be over-emphasised and Porter (1994:156) suggests practice is the very best teacher of all and you cannot do any harm if the intentions are for helping them. Although this could raise alarm bells for experienced therapists all too aware of the risks of uniformed practice. However, it could be considered a key factor is 'what' is being practiced and the extent of their training before commencing that practice. Furthermore, Philips and Buncher (2000) suggest that regardless of how well someone is trained, one of the greatest ways of differentiating one person's competence from another is to notice how much 'feel' they have when they are working, such as whether they work smoothly or with a lack of finesse.

The concept of practice can be considered as reaching beyond hypnosis induction and application of techniques. Lang and Laser (2009:34) suggest students take advantage of any opportunity to practice their non-verbal communication observation, whether sitting in a meeting or even on the subway, whereas Chips (2004) talks of practice to be able to create suggestions 'on the fly'. This could be seen as vital when working with hypnotherapy, where application simple insight-generating technique could significantly change the direction of the session in a moment and thus result in a completely different range of suggestions needed.

Hunter (2000) quotes Charles Tebbetts as saying there is no substitute for practice in order to develop confidence and competence with the art of hypnosis. Hunter goes on to indicate that students will learn far more about hypnotherapy from actual experience than any text book, trainer or manual. It is not mentioned in Hunter's book, but it can be questioned whether such practice may, at least initially, be best served by being supervised, both for the wellbeing of the subject and to keep the confidence of the student. Should the unexpected occur a very novice student-practitioner may not have the skills or knowledge of how to react most beneficially for the subject. Furthermore,

part of the practice process could be considered to incorporate 'reflection' techniques, both during the actual practice and afterwards. Schiffer (1998) suggests this can take the form of trying something out, reflecting on the outcome, and then developing it further.

Continuous Professional Development

"There are always more things to be learned" (Ewin, 2009:132) and training helps us to be useful to our patients (Hunter, 2004:183). Brookhouse and Biddle (2005) also agree there is always something to learn which can benefit you and your clients, suggesting even if the individual is the greatest expert on one topic, there will always be new angles. Although, Sanders (2007:96) cautions that regardless of how far a therapist proceeds with their training, they will find that their development as a helper never feels 'complete'. This should not stop any practitioner engaging in an ongoing process of professional development.

The CNHC introduced their CPD policy on 1st September 2011. Members must confirm completion of CPD when they renew and from 2013, the CNHC will check compliance by conducting random sampling (CNHC, 2011b). All verifying professional associations received information about the CPD policy (CNHC, 2011a). Some, such as the British Society of Clinical Hypnosis (BSCH) have discussed the topic internally, such as the BSCH at their Annual General Meeting and disseminated information to members that CPD training is now a requirement for professional membership.

Accreditation of training

It has been suggested (Mills 1996:49) that a safe practitioner's competence attainment must be verifiable and this was reflected in the CAM regulation White Paper. Furthermore, the Federal Working Group final report (2008) discussed accreditation of courses, considering the CNHC should establish criteria for the accreditation of courses, with professional assistance.

The UKCHO final Newsletter (UKCHO Newsletter 20) **(**UKCHO, 2012**)** also indicated that CPD and accredited prior learning will also be within the remit of the Hypnotherapy Profession Specific Board. The White Paper for CAM regulation (House

of Lords Science and Technology Committee, 2000, Summary IX, Chapter 6) suggests CAM professional bodies develop and support quality training programmes.

In the early CNHC minutes of meetings with Professional Associations (CNHC, 2009b, 2010a, 2010b) it is reported that there were plans to have education standards and an accreditation process in place in 2012. However, at the meeting on 23rd May 2012 the CNHC reported that they were waiting for information from the verifying organisations (CNHC, 2012a). At the last time of checking (3rd January 2013) there were no accreditation of training details on the CNHC website.

At present, many hypnosis professional associations' websites display details of training organisations who training meets the membership criteria standards set by the individual professional bodies. It could be considered beneficial for both the public, in terms of checking the training of a prospective therapist, and prospective students, in terms of educator selection, for a central list of training which is to the required standard, such that it meets the requirements of the National Occupational Standards and Core Curriculum. This was also recognised by UKCHO who considered that 'CNHC Registered' will give complementary healthcare practitioners the opportunity to demonstrate that they are *bona fide* and meet recognised standards of education and training (UKCHO Newsletter issue 17, Jan 2010) (UKCHO, 2012).

Trevelyan, on the topic of the future of complementary medicine offers some positive suggestions, firstly for a National Vocation Qualification and secondly for a common foundation course for all healthcare professionals whether they wish to become a general practitioner or a reflexologist. This would introduce health and disease after which the students could follow on to their chosen discipline. This may be well received by medical students, 15% of whom in a study by Funham *et al.* (1995), indicated a desire for CAM training. Such a concept would avoid the type of course first experienced by Bejenke (2012) which she found 'unethical and dangerous'.

Section summary

This section has explored the influences of legislation, regulation, and government white papers upon the hypnotherapy sector, particularly as relating to voluntary regulation and training. It has been seen that there have been many contributors to the

voluntary regulation process, which ultimately resulted in informing CNHC the voluntary regulator for the hypnotherapy sector. Other organisations, such as the PSA and professional bodies also contribute to the regulatory process. A fundamental element of regulation is the development and compliance with standards and the H.NOS which were developed and then reviewed several times prior to their current format, with the new associated Core Curriculum. It is to be predicted that some educators will recognise and be influenced by the H.NOS and Core Curriculum and incorporate these into their training provision. It is to be anticipated also that potential and current practitioners and researchers seeking training may look for training that meets these standards. However, it is also recognised that there are many factors that influence education and training and how people teach and learn have also been explored, together with the value of practice and ongoing development. It can be suggested that regulation, training and continuing development are all factors that would contribute towards an individual and a sector being considered 'professional' and this will be explored further in the next section.

2.5 Assessment of practice

Throughout this Review of Literature, there have been discussions relating to the definition of hypnosis, how it has developed over time, and current debates including the medical / lay practitioner divide. Hypnosis use is widely diversified, although, as Yapko (2003) indicates, it is not always labelled as hypnosis, and this can be associated with the myths and misconceptions which continue and, are even fuelled by the media and popular television programmes, such as 'The Mentalist' and personalities such as 'Paul McKenna' and 'Derren Brown'. It is suggested that no other psychological or psychotherapeutic therapy has such a following and application in entertainment spheres. Perhaps this could be considered a further challenge in the professionalization of hypnotherapy. This is further supported by the only legislation relating to hypnosis, with the 'Hypnotism Act 1952' regulating entertainment uses of hypnosis. Although there is no legislation addressing hypnotherapy, a government White Paper on CAM regulation recognised hypnotherapy as a therapy with some evidence base, although below that of those therapies currently subjected to statutory regulation. The White Paper recommended a voluntary regulation approach prior to statutory regulation. In addition to a voluntary regulatory body, a government initiative of National

Occupational Standards includes a set of standards for hypnotherapy and is supported by a Core Curriculum.

The H.NOS and Core Curriculum offer clear guidelines regarding relevant minimum knowledge, understanding and skills for the practice of hypnotherapy. However, prior to the research carried out in this study, it was not known whether professional bodies had accepted these guidelines, or whether educators had incorporated them into training. Furthermore, where educators had adapted or developed their training to do so, it was unclear whether practitioners and researchers were aware of this, or their views on the influence of these guidelines on teaching and learning.

An evaluation of the influence of the H.NOS and Core Curriculum could have been carried out if there had been any established form of assessment of practice in place enabling comparison of training to a specific profile. However, as has been discussed, apart from one University offering a MSc. Clinical Hypnosis award, there appear to be no nationally recognised qualifications. Clearly the MSc. assessed at level 7 (NQF), is of a higher academic level than comparable qualifications in other therapies, who tend to be focused around level 3 or level 4.

As has been discussed earlier, training courses are broadly varied and it is difficult for prospective hypnotherapy students to compare training offered, reinforcing the necessity for a tool for screening for practitioners. It is also difficult for trained practitioners to assess their training and compare it to others, thus an 'initial assessment' tool would provide a starting point for development. Furthermore, for those wishing to reflect on their training, make judgements about their performance, including 'desirable practice' (Norton, 2013) and plan their development, a diagnostic assessment tool would be beneficial. Such a tool could assist with the translation between clinical guidelines and practice, enabling reflective practice, self-assessment and critical analysis (Ellis-Jones *et.al*. 2013) whilst addressing needs for criteria and standards-based assessment (Thomson, 2013) and allowing a comparison of teaching and learning outcomes (Jones et.al. 2010).

It would seem sensible for the development of a combined tool to address screening; initial and diagnostic assessment uses to provide a simplicity and consistency of

approach, allowing for and recognising differences in levels of experience, and the skills, knowledge and understanding that the H.NOS and Core Curriculum consider necessary.

For any such tool, issues such as validity and reliability are important, as are the adaptability of the tool to meet different needs and be authentic and sufficient in terms of outcomes. There is also a consideration that the nature of assessment is reported to affect student approaches to learning (Cowen, 2005). The timing and approach of assessment is important (Brown and Glasner, 2003) and Cowen suggests 'assessment is the engine which drives student learning' discussing the appropriate uses of 'surface and deep learning' (Brown et al., 1994, Biggs, 1999). While surface approaches may be relevant for initial levels of training hypnotherapy teaching and learning, deeper approaches will be required as the student develops, to ensure they are able to assess client needs and adapt and synthesis therapeutic approaches as required. Thus, the tool would need to be sufficiently diverse yet balanced and appropriate for the environment and workplace in which it applies (Al-Kadri et. al., 2013). Dannefer (2013) reminds us that an assessment process can also foster learning and additionally support quality assurance. A 'good' assessment tool could be seen to benefit students, inform educators, as well as direct professional bodies towards the needs of members and their professional development, both initial and ongoing (Race et al., 2005; Cowan, 2005). It can be seen that the type of assessment tool discussed would have a benchmarking role, enabling comparison between training programmes and comparing learner outcomes. Furthermore, this may have an influence on training selection, provision, learning, teaching and 'return on training investment'. Such an assessment tool with benchmarking applications would offer relevant key performance indicators against which the training can be assessed. Camp (1989) advises that there are several factors to be considered when addressing benchmarking, including the tool's ability to consider similar training; diverse and best-practice programmes; identify targets for future performance, and enable review and recalibration. Therefore, such a tool could also be used for practitioner and researcher action planning for their ongoing development, enabling them to identify their current position; where they wish to be, and be able to identify the steps or elements required to reach specific targets. Plant et al., (2013) consider assessment approaches as an informed process where self-directed learning indicates a requirement for self-directed assessment of needs, whilst considering

learners approaches to self-assessment varies notably according to both learning and context, although Surgenor (2013) observed students have lower expectations than their tutors and Roberts (2013) suggests innovative tools are required to demonstrate cognitive abilities, integration of knowledge, complex problem solving and innovative thinking. Drost (2002) reminds us of the need to consider cultural differences and Beach (2008) student preferences, and the allowance of creativity and self-realisation.

It can be noted that little literature was available directly related to the assessment or benchmarking of hypnosis or hypnotherapy training and ongoing development. For this research study, to widely explore the influence of the H.NOS on hypnotherapy teaching and learning, there was a need to propose ~~for~~ a model or tool with which respondents could use to classify the extent of their training, in addition to identifying how the H.NOS would fit within this classification and where they considered a professional hypnotherapist would be located. As no appropriate assessment models were located, several learning theories and models were considered for their suitability to fulfil the identified function. These models tended to fulfil single needs and meet specific theories and none provided a good fit.

A behavioural approach may consider modifying behaviour based on reinforcement of desired behaviour and ignoring undesirable ones. Atherton (2011) suggests that this approach is related to psychomotor skill development, as opposed to learning cognitive content. It should be acknowledged that using this approach to teach hypnotherapy could have potential issues. To ignore 'undesirable' behaviour may result in students repeatedly engaging in poor or unsafe practice which, with repetition, may evolve into habitual behaviour. Furthermore, each student may have a different response to a single method of reinforcement, thus making this potentially less effective.

Humanistic theories, particularly those of Rogers (1980), Maslow (1987) and Knowles (1978) are focused around what 'ought' to happen rather than what does, with empowered learners, having control over their learning process. A feature here is that the teacher becomes a 'facilitator' thus relinquishing much authority. Whilst this may be appropriate for later learning, such as hypnotherapists exploring advanced or specialist material in a collaborative setting, it may not be appropriate to support the novice learner. However, Maslow's Hierarchy of needs model can be applied to

selection of training. Students may choose courses that fulfil basic needs initially, such as gaining skills to keep themselves safe in practice (such as at novice levels) and then progress on towards higher needs such as meeting self-esteem needs.

Kolb's (1984) cycle of adult learning and Honey and Mumford's (1982) typology of learners, addressing learning from an experiential perspective both consider learning approaches and may offer insight into the development of learning. For example, in Kolb's cycle, the concrete experience of learning a new technique would be followed by a process of reflective observation or post use reflection, thus developing in abstract conceptualisation and then active experimentation, applying the technique outside of the initial scope in which it was taught. This could be seen to be of benefit to assessing development of training, addressing the factual nature of initial learning as convergent knowledge (Hudson 1967) broadening out to divergent knowledge as training develops in complexity and diversity, together with both assimilative (fitting practice to theory) and accommodative (fitting theory to practice) learning processes.

The contribution from levels of understanding theories and models is also considered. Bloom's taxonomy (1956) and the later revisions by Anderson and Krathwohl (2001) demonstrated cognitive domains with remembering facts (recall) at the lowest level, rising to synthesis, evaluation and creation at the top level. However, Atherton (2011) suggests that at times, working at the higher levels (such as creating) is necessary to achieve the lower levels (such as understanding). From an affective domain perspective, Krathwohl *et al.,* (1964) suggest lower levels of awareness and receiving lead to higher levels, characterising implicit principles through analysis. In the psycho-motor domain, Dave (1975) suggests a hierarchy from imitation through to naturalisation. Atherton (2011) suggests the cognitive domain approach is popular with curriculum planners, although he challenges that initial learning must start with knowledge.

Beyond levels of understanding, also worthy of consideration are Bateson's (1973) levels of learning, ranging from direct experience leading to learning with generalisation of these experiences, followed by contextualisation of these learning experiences. This again can be considered a hierarchical process. In contrast, is Reynold's (1965) learning curve, progressing from 'have a go' and 'hit and miss'

through to ‘relative mastery’ and ‘second nature’ in which learning has been internalised. Atherton (2011) further suggests that the ‘progression of competence’ model of unconscious incompetence through to unconscious competence.

Dimensions of practice (Atherton 2011) are also worthy of consideration. Although an individual engages in the process of hypnotherapy willingly and the hypnotherapist undertakes the practice willingly, what the client wants and what the practitioner realises should be done in terms of best practice may differ, resulting in the practitioner practicing ‘unwillingly’. It could be suggested that in hypnotherapy this may require a deeper understanding of key concepts so that the practitioner is able to evaluate whether it is appropriate to practice unwillingly. For example, a client may present with obvious deeper issues, but only wishes to address a superficial issue. Furthermore, issues of witting (knowing) practice and unwitting practice (obeying rules without fully understanding why) are also relevant. Together these four aspects of practice lead to four modes of practice. Intentional (witting and willing) practice is doing what was intended and understanding why. To achieve this, a hypnotherapist must have a depth of knowledge and understanding. In contrast is survival (witting and unwilling) practice, where a practitioner may know what needs to be done but doesn’t do it. In hypnotherapy this can be knowing what treatment approach is indicated, yet does not have the resources, such as time, in order to do it so takes a short-cut. Consequences may or may not arise from this should cut. Shallow (willing and unwitting) practice relates more to ignorant practice and can be hazardous to therapeutic practice. A hypnotherapist may have a superficial awareness of a technique and its application, yet not be aware of the contra-indications, thus not checking for them when applying the technique. Driving (unwilling and unwitting) practice with ineffective training leads to ineffective practice.

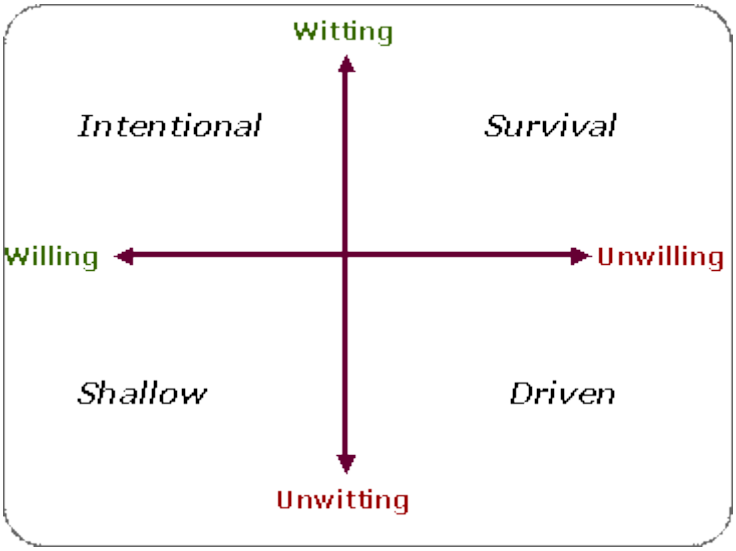

Figure 2.2 Dimensions of practice (Atherton 2011)

A range of stage theories were considered for their ability to reflect the anticipated development from a complete hypnotherapy beginner, through to someone at the top of their field. Stage theories consider that elements change as there is progression through distinct stages, each with distinguishing characteristics. Stage approaches and models can be very specific, such as the Buddhist stages of mastering the senses (Abhibhavayatana 1997), starting with mastering perception of self and then progressively developing beyond self or Bennett's scale (2004) with six stages of increasing complex perceptual sensitivity to difference. They may also be more widely applicable, such as Commons (Commons *et al.* 1997) Model of Hierarchical Complexity, with scoring for how complex a behaviour is, ranging from exactness, through sensory stages, to concrete, abstract and paradigmatic. In addition, Kohlberg's (1973) stages of moral development, consider moral reasoning as the basis for ethical behaviour with higher stages of moral development enabling greater decision making of ethical dilemmas.

A more focused model is the Dreyfus model of skill acquisition (Drefus and Dreyfus 1980) which relates to gaining skills through formal instruction and practice, moving from Novice, Competence, and Proficiency, through to Expertise and Mastery. Benner (2004) considers this model useful for understanding styles of learning and learning needs at different levels. Perhaps a more relevant model for hypnotherapy teaching and

learning is Eraut's (1994) view of increasing skill. The first level of Novice relates to rigid following of rules, with no discretionary judgement. There is a clear progression to Advanced Beginner with a limited perception of situation, and work aspects addressed with equal importance. Competent is the middle level, relating to coping with multiple activities, deliberate planning and some perception of actions relating to goals. The Proficiency stage is characterised by a holistic view of situations, with prioritising of importance and perceptions of deviations from the norm. This leads on to the final level of Expert, which indicates conduct beyond reliance on rules, vision of potential and intuitive grasp of situations, with analytical engagement in problems and new situations.

Despite consideration of a wide range of approaches and models, it was observed that none offered a clear means of classifying training in comparison to the H.NOS and Core Curriculum and in relation to professionalism, although many theories and models had individual points to contribute. These were used in the development of a unique model, the T.A.P. model (discussed in chapter three) to enable respondents to the questionnaires of this study to indicate their responses relating to their training and the H.NOS and professionalism as to where they were located on the T.A.P. model. This enabled comparison between respondents on a consistent basis.

Section summary

It is clear that there is a need to assess and compare provision of training, yet there are no single theories or models that would adequately address initial and ongoing training and development of professionalism. The T.A.P. model (chapter three) develops the key points from this assessment section.

2.6 Professionalising hypnotherapy

There is a tendency in modern language to refer to some roles as 'professional', thus the 'accounting profession', the 'teaching profession' and, the 'hypnotherapy profession'. However, whether the hypnotherapy sector has a good claim on that descriptor is to be explored. This section considers the key issues relating to professional hypnotherapy and the broader questions relating to professionalism, what a professional is and what professions are, including becoming a profession. This section also explores issues

around professional work, knowledge, skills and expertise before focusing on professional bodies, control and regulation.

Professional hypnotherapy

Despite the recommendation in 1955 of the Psychological Medicine Group Committee of the British Medical Association for practical and theoretical hypnotherapeutic approaches to be included in medical school training, Iphofen (2007) considers the legitimacy of the profession of hypnotherapy failed to be established at that time, as the recommendation would appear to have been disregarded (Scott, 1978, Heap and Dryden, 1991). It could be said that this resulted in generations of medical professionals with the potential view of hypnotherapy as something 'esoteric' and just hovering on the fringes of respectability or acceptance.

However, with a societal trend and transition towards personal healthcare engagement, and the public generally taking a more holistic approach, there has been an increase in the awareness of and demand for complementary (as well as conventional medicine) and alternative (instead of conventional medicine) therapies (CAM). This was recognised by the government with the White Paper by House of Lords Science and Technology Committee, with their report on CAM (House of Lords Science and Technology Committee, 2000). Worth considering is also the influence of the NHS plan (NHS, 2000) and the NHS modernisation agenda (National Audit Office, 2001). Following on from the White Paper, a range of stakeholders external to and from the hypnotherapy sector lead to the publication of Hypnotherapy National Occupational Standards in 2002. It could be said that such standards clearly define what is expected of a professional hypnotherapist. However, despite such standards, hypnotherapy has never been subject to regulation by the Health and Care Professions Council (regulatory body). Iphofen (2007) suggests that the British Association of Counselling and Psychotherapy (BACP) / United Kingdom Council for Psychotherapy (UKCP) expressed concerns with the structure of the HCPC, and suggested a separate Psychological Professions Council (BSCH, 2006) although this has yet to progress. There may have been a greater opportunity for hypnotherapy to join such a group as opposed to the HPC.

What is professionalism?

When defining professionalism, it can be recognised that the meaning has evolved over many years, with dictionaries and websites differing in their chronology of the word. Recognising these transitions, the Institute for Learning considered professionalism used to mean 'expertise, specialist knowledge, altruistic', then was a reaction 'mystification of knowledge, elitist, exclusive', before progressing to managerial concepts 'accountable, regulated, explicit standards', to the present views of 'accountability, integrity, self-regulation' (IFL, 2009). Reeves and Knell (2006) suggest the true professionalism of hypnotherapists can only come from the production of good work. This would appear more outcome than integrity focused.

The HCPC (2011) suggest professionalism can be understood in a range of ways including: as a holistic construct, a measure of clinical care, an expression of self, attitudes, behaviours, and a fluid construct according to expectations and contexts. Furthermore, they suggest there is a difference between the use of the adjective 'being professional' to the use of the noun 'being a professional'.

The Cabinet Office (2008), instead of offering a definition of professionalism, focus on professional traits and characteristics and the relationship between the professional in service and the citizen, whilst Friedson (2004:7) considers professionalism is a model for the conceptualisation of the control and organisation of the performance of work (p.173).

The structure of professionalism

There is a suggestion (Friedson, 2004:9) that professionalism is evolving into a hierarchical form with the professional elites exerting technical, administrative and cultural authority in the control of 'everyday practitioners'. Earlier work of Friedson (1988) suggests the hierarchy is professional not administrative, based on expertise. There are 'elite' in the hypnotherapy sector, with 'big names' writing books, giving talks, running training courses and, for some, engaging in research. However, these do not appear to have a high profile in the operation of the professional bodies, who can be regarding as those exerting technical, administrative and cultural authority. This suggested hierarchy of 'elitism' may also be identified by the levels in the T.A.P. model (Section 2.12). Those entering the profession may do so at the lower levels in the T.A.P. model, and increase over time.

What is a professional?

Whilst Eraut (1995) indicates that debate about what constitutes a professional has become sterile and not reflecting the changing nature of professional work, Friedson (2004:112) suggests that the proportion of professionally skilled workers increasing the professionalization of the labour force will increase in the future. However, Friedson (2004:128) goes on to say that professionals have always been treated as more than merely specialised workers. This appears to be supported by Spencer (1896) who considered that professions are singled out as occupations that perform tasks of great social value, because professionals possess both knowledge and skills that in some way set them apart from other kinds of workers. This may have relevance to the T.A.P. model (Section 2.12) with incremental levels of expertise. However, those to whom the title 'professional' can range so broadly, that Bell (1976) considered sub-classifications of 'professional', 'semi-professional' and 'technician'. Moreover, Friedson (2004:35) considers professionals do not constitute a 'homogenous aggregate'. Instead, the professionals differ by specialities and type of practice, together with their role, whether as 'rank-and-file' practitioner, educator, researcher or manager (professional association perhaps!), and by their influence in cultural, political and intellectual spheres within the profession and in the lay world outside.

Garland Fross (Arons and Bubeck, 1971) suggests that professional people have codes of ethics that are built-in with their training and education. However, hypnotists are not legally governed by ethics, although Anthony Jacquin, a therapist, and international trainer, suggests "with ability comes responsibility" (2007). Voit and Delaney (2004: 14) consider many therapists believe that because they are compassionate, professional caregivers they are implicitly ethical. However, it can be considered that in general, hypnotherapists are in private practice, and such practice is only subjected to the scrutiny of their clients, many of whom may have limited informed expectations as to their expectations of professional behaviour. Whether the hypnotherapist has the attributes of an effective practitioner (Morrison, 2005), is trained, experienced, ethical, or engaged in professional development is not generally questioned.

What are professions?

Perhaps simplistically, Goode (1957) indicated characterisation of a profession as a 'community', whereby a group shares a common experience and identity. with

Friedson (2004:170) suggesting 'profession' is a label used by lay people to a limited range of occupations which are regarded in some way as superior to ordinary occupations and which control their own tasks. However, while virtually all occupations that may be called professions can be classified as such in census categories and in general discussion, relatively few have the legal status of the professions (Friedson, 2004:26). Rather, Friedson (2004:10) describes a 'profession' as an occupation that controls its own work, organized by a special set of procedures sustained in part by a particular ideology of expertise and service. Furthermore, he described 'professionalism' as that ideology and special set of instructions.

Friedson (2004:15) considers there is a process by which the occupations claim or gain professional status, or 'profession construction' as Vollmer and Mill (1966) consider it, which (Fores and Glover, 1978:15) refer to as the British Disease, and Jewson (1974) link to a change in patronage (Johnson, 1972: 41-47) with a market for their expertise (Larson, 1977). Although, Form (1968:24) suggests occupational classifications are made to fit administrative needs.

Becoming a profession

In order to become a profession, it is suggested that an organised occupation may claim a competence beyond a lay person and that there is something above the laity in terms of the quality of its work and its benefits to society, in order to justify the desire to have an restrictive right to perform a specific function (Friedson (2004:62). Furthermore, Vollmer and Mills (1966) add that with such an exclusive right would come control of training and the access to such, together with having the right to determine and evaluate the way the work is performed and to whom may have access to that training. In the UK there are often close links between professional bodies and hypnotherapy educators and training schools. In some cases, a professional body will just offer their membership to those from their linked training school. These tend to be the smaller professional associations. Friedson (2004:36) recognises that there will be variation, suggesting there may be contending specialities, theories and practices, with differing knowledge and skills. It can be questioned whether hypnotherapy has developed yet into a profession and many professional attributes are addressed in Table 2.2.

Table 2.3: Is hypnotherapy a profession? Professional attributes and the hypnotherapy sector

'Professions'	**The Hypnotherapy Sector**
• 'Career for life'	• Once trained as a hypnotherapist there are no age barriers, nor, at present, mandatory ongoing competency requirements
• Code of Ethics informing service to others, which is ethically neutral towards clients	• Although practitioners do not have to be members of a professional association in order to practice, the professional bodies do have Codes of Ethics
• Control of professional body over relevant legislation	• Many professional bodies were consulted for the H.NOS and links are maintained with the CNHC - the voluntary regulatory body
• Control over admission to profession	• Although no mandatory requirement for training, nor specific entry criteria, the larger schools have varying entry criteria
• High occupational autonomy	• Practitioners usually work as independent professionals
• High prestige accorded by non-professionals	• Practitioners are able to offer a service that an individual is unlikely to be able to conduct for themselves to the same level of expertise
• Individualised service	• Hypnotherapists adapt therapy to suit what the client presents for

• Lengthy training	• Some organisations, such as for the MSc. in Clinical Hypnosis have lengthy training
• Professional body governs training	Professional bodies offer criteria for membership that informs training provision. Some professional bodies are more explicit with regards to what must be taught and to what extent
• Professional norms self-enforced / Self-policing, free of lay evaluation or control	• There is a degree of self-management amongst all hypnotherapists, without formal evaluation by those outside of the profession. Professional bodies will investigate complaints.
• Specialised abstract knowledge	• A hypnotherapist will learn a range of approaches and how to adapt these to suit individuals' needs

(Brande, 1975; Mumford, 1983; Friedson, 1994; Cockerham, 1995; MacDonald 1995; Godfrey 1999; Iphofen, 2007)

What is professional work?

In the foreword of the HCPC report considering the perceptions of professionalism (HPC, 2011), van der Gaag quotes George Bernard Shaw as saying that all professions were 'a conspiracy against the laity', although it could be reversed that the laity look for professions to achieve what they are unable or unwilling to do. The HPC study of twenty focus groups found that professionalism has a basis in individual characteristics and values (p3) with professional behaviour as the interaction of person and context and situational judgement. Furthermore, the report suggests that as opposed to a set of defined skills, professionalism may be better considered as a 'meta-skill'. Moreover,

professional behaviour was considered to be an expression of professional attitudes and identity (p6).

Professionals work can be considered as esoteric, complex and discretionary in character, with theoretical knowledge, skill and judgement required beyond what ordinary people would know, understand or be able to easily evaluate (Friedson, 2004:200). The work is believed to be especially important for the wellbeing of others, potentially with a prospect of danger for the public if such work was not controlled or was of a poor quality. Moreover, this work has three basic elements of professionalism: commitment to practicing a body of knowledge and skill of special value; maintenance of a relationship of trust with the client; and with a period of training to build esoteric and complex knowledge, which enables the competent performance of skills.

Professional knowledge, skills and expertise

Another key aspect of professionalism is the existence of evidence of training or 'credentialism' (Friedson, 2004:159). At present there are no nationally recognised 'credentials' for hypnotherapy. This would seem to support Friedson (2004:43) suggestion there is a pressing need for an adequate method of conceptualising knowledge itself.

The range of hypnosis and hypnotherapy training is difficult to estimate according to Iphofen (2007). Furthermore, on the topic of training, Iphofen suggests good course design starts with the desired outcome (such as meeting the H.NOS). Then an educator would consider such topics as curriculum and assessment (defining knowledge and competency requirements and how measure) and pedagogy (teaching approaches). Following training, practitioners will be initially inexperienced. Pederson (1994) suggests there are various levels according to competence, which link with the complexity of work that they are permitted to work with. Pederson's views appear closely mirrored by the T.A.P. model (Section 2.12) developed to assess training and related to H.NOS.

Professionals are considered to produce new knowledge and techniques by exploring their own concepts and theories (Friedson 2004:177). However, Friedson also suggests

that as practitioners are heavily involved in the day-to-day activity of serving others, it cannot be expected of them to be routinely engaged in scholarship and research.

Is expertise even at all necessary? Friedson (2004:157) suggests superior knowledge, skills and expertise performing tasks, with case by case discretion and judgement, denotes a professional as opposed to an amateurish job. A counter-argument proposed by Friedson is that any service could be standardised, citing an example of feet adapting to standard shoes as opposed to custom-fit shoes. It could be said that an example of this is the NHS 'Beating the Blues', which is an online, self-completion, computerised Cognitive Behaviour Therapy (CBT) programme. However, there can be criticisms of this approach, as it removes a significant aspect of 'personal service'.

The experiential knowledge of the personal service professions can be more than the lay individual would have. However, this breadth of experience could be considered as under challenge with the ever-increasing range of online chat forums, the storage capacity of computers and data retrieval systems and with the increasing education and availability of information sources to the lay population. More so now than ever, practitioners are being challenged by clients who 'Google' their condition and prospective treatment prior to their first consultation with a healthcare professional. This could be compounded by Friedson's view (2004:87) of the potential for exaggeration of the amount of knowledge, skills and judgement that is involved in some of their everyday work (Friedson, 1988). Such knowledge and skills are created within the profession. However, higher vocational education is considered (Friedson, 2004:99) to build expectation and commitment not easily overcome by policies or management approaches and whilst there have may been some consideration of the influence of knowledge (Halliday, 1985; Abbott, 1988; Larson, 1990) there is little discussed at the same time about its influence on policy making and culture. However, Anderson considers personal self-regulation as an effective form of professional control (Anderson, 2007).

Professional bodies, control and regulation

The Institute for Learning (IFL) (2009) consider that professional bodies have a crucial role to play in the regulatory landscape, further suggesting that professional membership offers the public, the sector and the government assurances that services

are being delivered by qualified and expert professionals, who are self-regulated to a code of professional conduct and standards. This is echoed by Friedson's view (2004:32) that professions have total power to control their own work, as they are organised by associations that are independent of the state. It is also suggested that some of the strongest professions have managed to keep the right to be arbiters of their work, justifying that by saying they are the only ones who know enough to be able to evaluate it (Friedson, 2004:84).

As opposed to expertise as the primary focus, Iphofen (2007) suggests, looking at Friedson's earlier work (1970) that the way expert knowledge is applied is based on power and privilege. Iphofen (2007) further suggests professional power is formal, bureaucratic and stable, with relationships between 'positions' as opposed to people (Dornbusch and Scott, 1975:37) although it is unclear where the power lies within the profession (Iphofen, 2007).

Whatever the format of the professional body, whether a union, guild, association (Millerson, 1964) it is supposed to have within its organisation a limited number of officials who are able to lobby and negotiate with authority on behalf of the entire membership with the reasonable expectation that the membership will support them.
Where such negotiation takes the form of regulation, standards or 'formal rationality' (Friedson, 2004:212) it can be found that there can be an elimination of as much discretion from work as possible and to employ fixed and objective criteria for evaluating it. This can result in a formal quantitative framework of standards who, although established members of the profession and who serve as cognitive authorities and provide professional legitimacy to hierarchical methods of regulation and control can have their actions seen as a considerable challenge to the autonomous professional. As put by Friedson (2004: 210), "in order to do good work, one must have the nominal freedom to exercise discretionary judgement". Such judgement can be held accountable with the formalisation of professional controls, although it is suggested (Friedson, 2004:165) that the disciplinary boards maintained by professional associations seemed to act slowly if at all in response to consumer complaints, with formal expulsion or sanctions rare (Carr-Saunders and Wilson, 1933:395) and this can cause hostility. Oppenheimer (1973) considers measures focused on greater professional accountability can arise from clients' demands for better services. There can be a view that restrictive

licensing focuses, from a public benefit perspective, on approved training to assure a minimally acceptable level of competence in performance of a specific set up tasks (Shimberg et al 1973). However, few occupations are organised in such a way as to have professional autonomy or what Johnson (1972) called collegiate control.

On the topic of future prospects for the professions (Friedson, 2004:74) regarding an increase in the strength of the professions, the extent of knowledge and skill, and occupational organisation are to be considered.

Professionals, hypnotherapy and the NOS

Fournier (1999) and Miller and Rose (1990) interpretations of government of professional practice 'at a distance' could be considered highly relevant, although it is can be questioned whether that distance is evermore closing. Furthermore, Freidson's (1994, 2001) views of professionalism and its form of occupational control of work is of significant relevance to this research. Although, Fonagy (2010) suggests that the NOS will not affect 'the magic' it can be questioned whether such close regulation will regulate out the 'sparks of inspiration' that can result in psychological therapy breakthroughs. As Clarke *et al.* (2004) considers the professionalisation of complementary and alternative medicine (CAM) practitioners leads to individuals who are subject to regulatory authorities with national jurisdiction it can be wondered whether such regulation will expand or constrict the work of professionals.

The historical meanings and functions of professionalism range from Durkheim (1992/1950) moral community of occupational membership through to Parsons (1951) debated (Dingwall and Lewis, 1983) contribution to social order and stability, a view also taken by Perkin (1989). It has been seen in this chapter that there are differences between lay and medical hypnotherapists and for hypnotherapy to move forward as a profession, the occupation of the community may need further adjustment to bring both dimensions towards greater compatibility. Although Davies (1996) considers professionalism is a misguided belief system, Saks (1995) considers that private and public interest can be met simultaneously. Further, there are views (Hanlon, 1999) of professionalism being refined to be more commercially aware and it could be considered that this is slowly developing within the hypnotherapy discipline. Worthy also of consideration is Friedson's views (1994, 2001) of professionalism and its forms

of occupational control of work. This is significant and relevant to this research considering the influence of the H.NOS, particularly as the H.NOS describe the knowledge, understanding and skills of a practitioner. It could be questioned whether this description of skills exerts a control of direction of training and ultimately work.

Section Summary

This section has considered the key views on what professionalism actually is, its structure and what makes a professional, whilst considering the essential characteristics of professions and how they become a profession. Also considered are questions around what is professional work, the relevance of professional knowledge, skills and expertise, together with the roles of professional bodies in control and regulation. With hypnotherapy falling under the remit of voluntary regulation, it does not have a protected title, in the way statutory regulated fields do, such as nursing, psychologists and osteopaths. However, the voluntary regulation requires, of practitioners, conduct which is similar to regulated professionals, such as training to a minimum standard; ethical conduct; reflection; supervision and continuous professional development, as described in the H.NOS and associated Core Curriculum. Thus it can be asked whether the H.NOS, which the voluntary regulatory body consider to be the appropriate standard for hypnotherapists are actually having an influence on professionalism, or whether the standards are poorly recognised or followed.

2.7 Summary

From the discussion throughout this chapter, it can be observed that there is, as yet, no single guiding force within the hypnotherapy profession, with each sector and group following the own path, which may, or may not, follow the standards outlined in H.NOS and the Core Curriculum. It can be questioned therefore whether these standards have any influence upon either how new and existing practitioners are educated nor upon the ongoing professionalism within the sector, thus leading to the two research questions intending to analyse the influence of the H.NOS on teaching and learning and on professionalism.

This chapter commenced with a consideration of definitions of hypnosis and hypnotherapy, a historical overview and current understanding. ‘What is hypnosis?’

illustrated the range of views and perceptions of the nature of hypnosis and then explored the relevance of the history of hypnosis and some of the prominent and persistent debates. Applications and the scope of hypnotherapy use were also considered in this section together with emergent issues, the profile of users and practitioners and whether hypnotherapy can be considered a therapy in its own right, or best serves as an adjunct to other therapies.

Key issues were addressed relating to legislation, regulation, standards, curriculum and training highlighting that there is little direct legislation and regulation in the hypnotherapy sector, although two government White Papers and several organisations, some part funded by government initiatives, were influential in the progression toward voluntary regulation. The voluntary regulator, the CNHC and alternative regulators, verifying organisations and professional bodies were all explored and key issues deliberated. The launch of the H.NOS and most recently the Core Curriculum setting the minimum standards for knowledge, skills and understanding for a hypnotherapist and providing eligibility for registration for CNHC, were explored and debated.

The influence on professionalism, and professionalising hypnotherapy was examined in relation to education and professionalism and their relationship with hypnosis and hypnotherapy, identifying a need for comparison and improved assessment. These together with an examination of key of theories and models, contributed towards the development of the T.A.P. model.

The following chapter ‘T.A.P. model’ (chapter three) will explore a Thought, Action, Professionalism model developed for this study to assess and classify training and development for practitioners and researchers, together with providing educators and professional bodies with means to indicate how their training and standards relate to the H.NOS and Core Curriculum. The development of this model is discussed, together with potential hypnotherapy and wider applications.

3. THE T. A. P. MODEL

3.1 Introduction

This chapter considers the rationale for the T.A.P. (Thought, Action, Professionalism) model and its subsequent development, pondering some of the key learning and teaching influences. It then reflects on how the T.A.P. model relates to the H.NOS and the Core Curriculum and the use of the T.A.P. model within this study.

The T.A.P. model was developed due to a lack of comparable models and it is proposed that the model has applications beyond this study specifically in the use of training; screening and selection; initial assessment post-training, and during the ongoing development and CPD stages which may include reflection and action planning. Furthermore, this chapter will explore the potential for wider applications of the T.A.P. model.

3.2 Rationale and development of the T.A.P. model

Rationale

This study intended to assess practitioners' and researchers' training and development, and gather their views on where H.NOS sat in respect to extent of training. Furthermore, this study sought to measure educators' and professional bodies' views on how H.NOS fit with their teaching and standards.

A wide-ranging review of teaching and learning and professionalism models (see chapter two) failed to locate an ideal measurement tool for this study and thus, following substantial secondary research and subsequent qualitative analysis, the T.A.P. model was formed. This was achieved by summarising the models reviewed and distilling down the information, resulting in the 'T.A.P. model' (Appendix A6) used in the questionnaire surveys.

Development

After an initial consultation of Brenner's (2000) views in '*From Novice to Expert'*, the starting point for the model was Bloom's Taxonomy (Bloom,1956), with its model for

academic education focusing on a mastery of subject and promoting higher levels of thinking as opposed to a simple receipt of a transfer of facts. It is perhaps a sad reflection that in some educational environments, and specifically in CAM and hypnotherapy training, that such a 'chalk-and-talk' approach, often the modern day equivalent being 'death by PowerPoint', is still the key method of transference of knowledge, focusing on factual transference and using recall of information as an indicator of learning. In preliminary investigations prior to the outlining of this research study, the majority of courses attended and observed revealed that almost all the theory information provided was in a 'transfer' format of some form.

Blooms Taxonomy (Bloom, 1956) provides an important foundation for the design, delivery and evaluation of training which can assist in the formation of a framework focused on achieving the desired capabilities, and of relevance to the field of hypnotherapy. For example, if it was desired for a graduate to achieve T.A.P. level four upon graduation, then training can be designed to ensure all six T.A.P. factors are covered in sufficient quantity and depth. Presently, much training currently written appears to focus on what knowledge is required to be transferred as opposed to desired outcomes in terms of understanding (knowledge and attitude) and skills.

The Oxford Dictionary considers knowledge is 'facts, information and skills acquired through experience of education; the theoretical and practical understanding of a subject'. It can be accepted that some knowledge will be gained post-qualification, whereas other knowledge may be required to allow such later knowledge to develop.

An attitude is considered a settled way of thinking or feeling, typically reflected in a person's behaviour (Merriam-Webster dictionary), with emotional, cognitive and behavioural components, which form as a direct result of experience. However, attitudes towards both the concept of hypnosis and the practice of hypnotherapy are unlikely to be fully formed prior to studying the topic. Balanced tuition, it is to be hoped, will enable the student to develop knowledge based on fact and experience to support their attitude evolvement.

Fnally, skills are generally the term given to the specific ability to do something with expertise, which comes from deliberate effort to conduct complex functions involving

cognitive and technical skills, and potentially interpersonal skills. It is, without question, vital for a qualified hypnotherapist to be able to conduct themselves with an appropriate skill set in their interactions with healthcare colleagues and their clients or patients. Reynolds (1965) model of developing skill, suggests consistency is important, with 'soaking in' so that performance becomes less self-conscious and developing a freedom to concentrate on other things with the final stage characterised by an ability to teach the skills. This could be reflected by the number of graduates of the larger teaching schools going on to teach at the same school, often before branching out on their own. Some schools even encourage this. The LCCH have a 'lecturer training programme' where qualified graduates observe teaching, gradually presenting sessions under supervision, until they are deemed by senior staff as ready to teach unsupervised.

Together, it could be considered these three components (Knowledge, attitudes and skills cumulate in competence appropriate to a specific level of responsibility or performance. However, Atherton (2011) considers that a learning curve is not a straight progression between competence and trials/time, but has a start, a plateau, a trough and a decline during the journey, before resulting in advancement to the next level.

Bloom (1956) worked with Englehart, Furst, Hill and Krathwohl in the development of a classification of educational objectives for learning, with six levels: Knowledge (recall); Comprehension (understand); application (solve); analysis (differentiate); synthesis (construct, create); and evaluation (judge). The 'Taxonomy' considered three 'domains' of cognitive (thinking), affective (attitude) and psychomotor (skills) with different levels within each domain. This model played a guiding role in the development of the T.A.P. model. Bloom's model was developed further by Anderson and Krathwohl (2001) with more focus on the psychomotor domain. Dave's (1975) view on psychomotor skills is commonly referenced on this subject, as are both Simpson's (1966) and Harrow (1972). Dave's model tends to be associated with adult training in the workplace and relevant to hypnotherapy where hypnotherapy training is provided to adults for a vocational purpose.

Also influential in the T.A.P. model development was Simpson's model (Simpson, 1966), which, according to Atherton (2011), can develop adults out of their comfort zones with progression of mastery from observation to invention. This is perhaps one

of the most significant models for learning hypnotherapy as its' seven levels progress from basic recognition (perception, level one) through comprehension (set, level two), to simulation, with imitation of a person or act (guided response, level three) through to a learned response becoming habitual (mechanism, level four) with confidence and proficiency. The next three levels appear to develop an individual beyond the general level to which an individual may initially aspire. Level five, (complex) works with resolution of uncertainty, whereas level six (adaptation) requires adjustment of established processes and the final level, seven (origination), invents, creates and develops new processes. It could perhaps be suggested that a practitioner, once qualified would reach level four, gain experience (level five) and with that start to adapt their work (level six) before, potentially, going on to generate an original approach or concept (level seven).

Whilst hypnotherapy could rarely be considered a physical activity, it does require an extensive skill set. Harrow's taxonomy (Harrow, 1972), considered for its skill development in the application of physical ability, from reflex movements through to sophisticated body movement focused communication, has similar aspects with these other taxonomies, although it is more focused on the physical. Whilst initially it could be questioned about its relevance to hypnotherapy learning, much of hypnotherapy training is very practical, with the application of hypnosis and hypnotherapeutic techniques.

Teaching hypnotherapy requires a blending of training across three learning domains: Cognitive, Psychomotor and Affective. The cognitive domain would appear to attract a high profile, reflecting learning related to knowledge, taking into consideration intellectual skills and cognitive strategies (Bloom, 1956; Gagné and Briggs, 1979; Anderson and Krathwohl, 2001), both in considering the theory relating to hypnosis and the relevant techniques. This seems to fit with Trudeau's 'five stages of processing information' of think, emote, look/search, create and then know (Trudeau, 2005). The psychomotor domain of action and motor skill learning, fits with Dave's model (1975) of developing skill from imitation to naturalisation is as relevant with hypnotherapy being a 'doing' therapy in terms of applying a range of techniques.

Perhaps less recognised, is the affective learning domain, yet attitudes and emotions are relevant in a therapy where rapport, empathy and 'unconditional positive regard' (Rogers, 1961:283-4) are an essential aspect of client-focused work. Krathwohl *et al.* (1964) scaling from receiving to characterising by value also influence upon emotional and attitudinal aspects of client and colleague interactions.

In addition to consulting a range of models, as previously explored, theories relating to how individuals learn were considered for their influence upon resulting aspects on any of the six TAP factors. Atherton (2011b) suggests that deep and surface learning approach studies (about responses to being taught) are based on the research of Marton and Säljö (1976). These are further developed by Entwistle (1981), Biggs (1987, 1993) and Ramsden (1992) and the two classifications correlate with intrinsic (deep) and extrinsic (surface) motivation. It could be suggested that a deep approaches develop understanding beyond what is taught, whereas surface appears to learn in isolation with connections. Säljö (1979) considers learning has different meaning to different people, in terms of acquiring information, memorising, retaining and then using, making sense of, or understanding reality in different ways. Altherton (2011b) suggests that making sense of different realities relate more to deep learning whereas knowing, remembering and using, relate to more surface strategies. A systematic examination of the schedules of teaching for a range of hypnosis courses (from internet searches) indicate that some teaching is provided on a range of subjects on a given day and that this training is built upon, thereby, enabling surface learning to develop to deep learning. Where entire modules are taught consecutively, it could be considered the deep learning comes later.

Learning complexity which develops during a course could related to the SOLO (Structure of the Observed Learning Outcome) taxonomy of Biggs and Collis (1982) and Biggs and Tang (2007) with five stages ranging from obtaining unconnected segments of information through to abstract connections and generalisations. Such an ability is necessary for a hypnotherapist. Unless an individual has a 'script' for every possible variation of every possible condition and combination thereof, there is a need to adapt techniques to suit individual clients.

Bateson (1973) suggests a hierarchy of learning from direct experience, through generalisation and contextualisation of learning to beyond contextualisation.

Whichever approach a trainer had been influenced by, Atherton (2011c) makes a strong point that teaching does not short cut the process that for some things, they are only learned by a combination of experience and practice.

A starting point for development of behaviour and conduct (TAP model level one), imitation, as discussed by Blackmore (1999) and social learning theorists such as Bandura, has implications for all three domains (affective, cognitive and psychomotor). It will often observe a process rather than specific content and thus how a hypnotherapy demonstration is provided is important for development of positive behaviours.

In the development of the T.A.P. model, consideration was also given to situated learning (Lave and Wenger, 1991), as a social learning approach is also influential in how hypnotherapists learn and develop into members of a 'Community of Practice'. Their 'legitimate peripheral participation' does seem to reflect the hypnotherapy community. It starts with acceptance (legitimate) on 'unqualified people' initially interacting with other new people (such as in study groups). They start with peripheral tasks, such as learning inductions and developing into basic techniques (peripheral), becoming more experienced and skilled through 'doing' with their knowledge (participation) located in the community of practice. Atherton (2011) suggests an important link to the view of Bourdieu (1977) that knowledge is performance, with knowledge validity achieved only within a community of practice.

Behaviourist approaches form the basis of many hypnotherapy techniques and are often the first element taught. Classical conditioning with 'stimulus-response' reflex learning (Pavlov 1927, 1957) will influence how students learn practical skills by association, creating memory 'anchors'. The operant conditioning of Skinner (1938), Thorndike (1905) and Watson (1913, 1920, 1934), with behaviour modification by reinforcement and extinction, could be seen to be more allied with the safe and effective refinement of practice skills. Thus, in the early development knowledge, skill acquisition and the shaping of behaviour, a directive approach may offer a measure of safety and control. However, it could be considered that even with a directive approach, teaching can offer more than 'transfer of information' and memorisation which Hirst and Woolley (1982) suggests goes back to mediaeval times where scholars did not have access to books.

A range of cognitive, constructivist and conversational theories were considered for their influence upon learning and development. Cognitive approaches relate to how people understand taught material in terms of learning style, aptitudes and capacity to learn. Although learning styles, such as 'Visual, Auditory, Kinaesthetic' fall within cognitive theories, the Learning Working Group (2004) suggest a lack of evidence of many categorisations of learning, citing variation in learning styles being individual as the basis as opposed to being fixed. However, they are of relevance as students of hypnotherapy will become aware of their own 'modality' preferences during their training, as suggestions and visualisations employ them. Thus, they may transfer this awareness to their learning. .

Cognitive approaches also lead into constructivist theories. Atherton (2011) suggests 'constructivist' labels theories which fall between cognitivist and humanistic views, with cognitive constructivists addressing how the individual learner understands things from a development and learning approach perspective. In contrast, social constructivists, such as Vygotsky (1962) consider how understanding arises from social encounters with the learner actively making meaning. Such an approach works well for those participating in hypnosis tuition, as they will be able to discuss and explore course content whilst actively processing the material. Vygotsky's (1962) 'Zone of Proximal Development' offers considerable insight for the T.A.P. model with its progression from 'cannot yet do' to 'can do with help' and 'can do alone'. This reflects much hypnotherapy technique learning. Such development can also be observed with conversational approaches, such as those of Laurillard (2002), and Thomas and Harri-Augstein (1977). This has the learner as an active 'maker of meaning' with the teacher working to understand what meaning the material has to the learner, with an interaction between theoretical and conceptual representations, refining with reflection and adaptation, until it relates to that of the teacher. With hypnotherapy learning this could lead to the development of a technique from a broad concept to a specific situational approach.

As students gain a basic level of knowledge, understanding and skill, experiential learning approaches can become appropriate and relevant. Whilst Laurillard's approach can be taught prior to first engaging in a practical session, with Kolb, the concrete experience is followed by reflection on that experience which leads to abstract

conceptualisation and modification leading to active experimentation and thus back round to concrete experimentation. Thus, this is an approach that may be more useful for the development of adaptations to and individualisation of techniques. Honey and Mumford (1982) take this further into developing types of learners with 'Activist' doing (Concrete experience), 'Reflector' observing (Reflective Observation), a 'Theorist' understanding concepts (Abstract conceptualisation) and 'Pragmatist' trying things out (Active experimentation). It is reasonable to consider a hypnotherapy class is likely to have a range of learners within each of these typology and this can be useful for a teacher, particularly during group work, to arrange a mix of each type to grow the group beyond individual capabilities.

The humanistic approaches to learning including those of Rogers (1980) Rogers and Freiberg (1994), Maslow (1987) and Knowles (1980) are reflected in some hypnotherapy training. For example, it could be suggested that a teacher would need to be confident in their authority to relinquish it and become a facilitator within a humanistic teaching approach, empowering their students to have control over their learning process. The approach, associated with Carl Rogers, (1969) (Rogers and Frieberg, 1994) involves the student participating completely in the learning process, yet more advanced training can take a more discursive and exploratory approach enabling learners to work more at T.A.P. levels five to seven. In order to achieve this, the earlier levels have to have been achieved, in the way of Maslow (1987) with his humanistic notion of pre-potency whereby basic needs must be met before the higher self-actualisation needs. Furthermore, with andragogy (Knowles 1990) there exists an understanding that adult learners need to know why they need to learn something before learning it, and that they are capable of self-direction and life experience, although it is acknowledged that this can bring bias and presupposition. This would seem to fit well for training hypnotherapists at higher T.A.P. levels.

The preparation of the T.A.P. model also acknowledged the potential for tacit (unspoken knowledge) and implicit learning, which relates to a not knowing what you do know. Polanyi (1958) talks of the content knowledge that is routinely used and taken for granted. Sternberg and Horvath (1999) consider the implications of tacit knowledge in professional practice (such as interpersonal skills), whilst for Berr (1997) and Reber (1967) it is about process learning. For example, practice may increase an

ability to conduct a task, yet the individual may not be able to answer questions on how they did it.

A final element of the preparation of the T.A.P. model was consideration of critical reflection and reflective practice. Mezirow (1990:5) considers these crucial to learning, and ignored by learning theorists, although it appears to be clear in Kolb's learning cycle and it is suggested that these are essential elements during both training and ongoing development of hypnotherapists, both reflecting 'in' action, during work with clients, as well as 'on' action, subsequent to the session. Schön (1983) suggests the capacity to reflect on performance engages in a continuous learning process and is a defining characteristic of professional practice.

3.3 The T.A.P. model

The model has seven levels and may be regarded as progressive, from (1) Beginner, (2) Novice, and (3) Intermediate, to (4) Practitioner, and them on to (5) Senior Practitioner, (6) Specialist and finally (7) Authority. The T.A.P. model then has a grid of six factors under two heading of 'Thoughts' and 'Actions' which indicate a measure of professionalism. Together, these factors are considered to represent a degree of professionalism and a measure of training in terms of knowledge, understanding and practice. Each factor progressively increases in complexity or development through each of the seven levels.

Thoughts

The 'Knowledge' category places 'minimal and unconnected' at level one, which can be regarded a simple collection of facts about hypnotherapy, used in isolation. Level two refers to 'direct experience, simple connections' and this progresses to 'application beyond direct experience' at level three. Here, a practitioner may use a range of knowledge from varied sources to interact beyond the strict wording for their therapy. As the practitioner develops, they gain a proficient body of field knowledge (level four) leading to an enhanced field knowledge (level five) which would be appropriate for the 'title' . From this point, knowledge may focus more narrowly, as opposed to broadly and deeply, with level six specialists having an enhanced knowledge of their specialism, such as weight loss specialists, smoking cessation experts, and many researchers. At

level seven, an authority will be a creator of new knowledge. This level is achievable within the hypnotherapy sector, with many prominent figures creating new systems, and processes, although fewer, such as Milton Erickson, creating an entire new paradigm (Ericksonian hypnosis).

The 'Understanding' category at level one indicates little understanding of the basic concepts, progressing to some understanding of the basic concepts at level two and connections at a theoretical level at level three. It could be suggested that this is the first level at which a practitioner may operate sufficiently, and more effectively at level four with extraction of specific learning from implicit rules. A more experienced practitioner or researcher may attain level five, creating meaning out of new experiences and this could be considered to be an element of reflection. Specialists at level six will be able to relate theory from professional experiences, and thus develop increased flexibility of approach, and finally level seven authorities may consider themselves enlightened and able to use abstract conceptualisation.

The third category in the Thoughts section is 'Decision–making' and decisions are made with assistance at level one. This may be as simple as gaining help in the appropriate selection of a hypnotic induction or deepening technique. With level two the individual is able to break the problem down, and thus bringing in their understanding and knowledge. At level three, there is a sense of what is relevant, at level four, adjustment to initial decisions. Thus if an initial decision to use a particular technique during therapy is showed to be ineffective, a practitioner could revise their decision and consider whether to change approaches or persist. At level five, an individual is responsible for identifying strategies to changes, which reflects an understanding of creating meaning out of experience. At higher levels of specialist, level six, there is adaptation of strategies through change, and simplification and strategies for complexity at level seven. At these higher levels, decision-making and undertaking are closely linked.

Actions

The first category in the Actions section is 'Skills / Ability' where individuals at level one imitate skills with assistance, progressing at level two to replication with minimal assistance, and, at level three, gaining refinement with supervision. At this third level,

for a trainee hypnotherapist, they may be able to work on their own with a colleague or client, but may require more close supervision or more access to supervision than those at level four, working unsupervised. It is recognised that hypnotherapists should work within clinical supervision and that is considered appropriate at all levels of work with the public, and different to supervision of developing skills. Thus, in a teaching environment, the first two levels would require close supervision in the classroom, and the level three less direct supervision. At level five, there is an expertise, with practiced skills and perhaps demonstrating a 'flair' progressing on to level six and highly developed expertise. At level seven, there is an expertise and ability to work beyond established protocols and perhaps creating new ways of working. It can be recognised that these higher levels relate to the individual's current training and qualifications. Thus when they attend a new development course outside of their immediate knowledge they may have a lower skill level and then need supervision. However, as a trained practitioner, they may be less accustomed to working under supervision, as they will may have done as a student. Thus potentially less comfortable with receiving feedback on their performance.

The second category in Actions is 'Communication' with basic communication on key concepts indicated at level one; at level two, a personal view is developed of basic concepts, thus perhaps indicating a preference of one technique over another, whilst at level three, an individual is able to discuss key concepts. This comprises a discussion of the components of a hypnotherapeutic approach and the degree to which they had worked during a session. As the individual develops their competence, such as at level four, they are developing their views on topics in the field, and, at level five, these views are becoming more established. At the higher levels, six, there is contribution to the field knowledge, whether in the form of articles, forum contributions, teaching, literature or some other format and at the highest level, seven, the individual is able to be a creator of knowledge within the field. Thus, they will have fully developed their 'voice' and have the supporting attributes for that voice to be heard.

The final category in Actions is 'Behaviour/ Conduct' with level one individuals having a need to follow or imitate others; at level two, they start to develop changes in their own behaviour, with, at level three, acquire sufficient behavioural changes to meet their perceived role. The first two levels and potentially the third, could be considered

'student' levels. At level four, there is a development of credibility and at level five, self-monitoring, a further link to the reflective process, progressing further to responsibility of, and an example to others at level six, with the evolution of high status / high esteem at level seven.

Given the highly diverse and eclectic nature of hypnosis and hypnotherapy, it is reasonable to suggest that different approaches, techniques and situations may be adequately conducted at lower levels than those of practitioner, for example, a simple hypnosis induction and re-alerting. Moreover, some tasks, such as detailed research in a psychology laboratory, may require a level higher than those of a regular practitioner. Furthermore, it would be expected that student learning abilities and preferences may influence their resulting development from training and, although their training may be written at level four, they may have absorbed more cognitively than practically. The progression through the model as a result of experience must be considered for what it adds to an individual's development.

3.4 The T.A.P. model and H.NOS

As discussed in the Review of Literature (chapter two) the H.NOS consist of four separate documents. CNH1 'explore and establish the client's needs) is a general standard relating to complementary and natural healthcare and CNH 2 'Develop and agree plans for complementary and natural healthcare with clients' are both general NOS and apply to a range of therapies. CNH23 'Provide hypnotherapy to clients' and the 'Principles of good practice' are both hypnotherapy-specific.

The T.A.P. model, as described in section 3.2, is structured in terms of 'Thoughts' 'Actions' and 'Professionalism' and thus the H.NOS criteria for skills, knowledge, and understanding criteria will not directly map to the T.A.P. model. However, this section will consider how the H.NOS and Core Curriculum are met by various categories in the T.A.P. model. It can be observed (see Appendix A7) that not all categories relate equally to all individual aspects of the H.NOS.

It can be observed that knowledge and understanding were generally mapped throughout. This could be considered appropriate as for each of the elements in the H.NOS there would need to be an awareness of the topic and an understanding in order

to carry out that element. Some of the elements also indicate a need to use that knowledge and understanding in order to make decisions. Around half of the elements were considered as falling within the category of 'knowledge and understanding' and the other half that of, 'knowledge, understanding and decision-making'. It may also be noted that generally, 'skills, communications and behaviours' all applied to most elements, with 'communication' not relevant for only a few elements.

The language used in the H.NOS also indicates the attributes required. Words such as 'explain', 'define', 'illustrate' and 'describe' indicate a need for knowledge and understanding together with communication skills, the ability to achieve the element (skill) and appropriate behaviour to do so. Other words, such as 'identify', 'assess' and 'evaluate' go beyond the knowledge and understanding aspects and require decision-making. Some words appear more skill-based, 'recognise', 'advise' 'explore' and 'demonstrate' are examples here. There also is a requirement to synthesise information with one element asking hypnotherapists to 'relate' (CNH23: *relate the links between case evaluation and selected approaches*...)

Overall, as can be observed (see Appendix A7) the categories within the T.A.P. model are highly relevant to the different elements in H.NOS.

3.5 Use of T.A.P. model within this study

The T.A.P. model chart (see Appendix A6) was included in the online questionnaire (Appendix A13, A14, A15, A16) and each of the four respondent groups (practitioners, researchers, educators, professional bodies) were asked a range of similar questions, which were adapted to focus on the specific needs of each group.

Both practitioners and researchers were asked what T.A.P. level they current met and what T.A.P. level they considered the H.NOS best reflected. They were also asked what T.A.P. level they considered practitioners should achieve at qualification. Additionally, researchers were also asked what T.A.P. level it was considered a researcher should achieve.

Educators were asked what level their practitioner (qualification) training best met and what level they considered practitioners should achieve at qualification. They were also asked to indicate what level they considered the H.NOS best met. Similar questions were presented to professional bodies, simply referring to their training requirements, rather than their training.

3.6 Hypnotherapy applications for the T.A.P. model

Should an individual wish to gain insight into which hypnosis or hypnotherapy training would be most suitable for themselves, they may wish to consider a range of factors, including location, duration, cost, reputation and content. Many factors are specific to the individual, such as how far they wish to travel and these are often simple to compare. However, although a list of course content can be compared, the depth and scope of that content is rarely outlined. A perceptively simple 'Introduction to Hypnotherapy' workshop may range from a light and general factual overview, to an intense immersion into theory and practice. Thus, it could be anticipated that the learner outcomes may be notably different.

For practitioners and researchers, the T.A.P. model can be used to initially screen prospective training providers, prompting a key question such as 'How is training provided?' Prospective students are able to consider where the prospective training fits to the T.A.P. model. They are also able to consider where they wish to ascend to in the model and look for training offerings that will provide this.

In addition to screening of initial training, those who have undergone qualification training may plot their training to gain an 'initial assessment' benchmark reading, which can be used for development and action planning and, with ongoing reflection, this process can continue until the individual reaches 'authority' level in all realms. The T.A.P. model allows for and recognises development from experience, as well as development anticipated from further training. Educators may wish to use the T.A.P. model to align their training offer. For example, their 'qualified hypnotherapist' training may presently meet all the criteria for T.A.P. level 4, apart from in the realm of communication. Thus, this shortfall area would benefit from review. Professional bodies may also wish to use the T.A.P. model to determine where their standards are

located ~~fall~~ and where they wish for them to fall, thus identifying areas for development.

It is suggested that there may be a broad range of applications of this model in areas of training and development. The model will fit well for training assessment and planning / development of physical and psychological therapies, whether voluntary-regulated complementary and alternative therapies, such as aromatherapy, reflexology and massage, or statutory-regulated therapies such as the psychotherapies, acupuncture and osteopathy. It is proposed that this model has an application to any job role where there is a need for subject knowledge, with use and evaluation of that knowledge and undertaking, including decision-making, together with a need for action, with skills, communication and a type of behaviour. Although the initial T.A.P. levels may have been achieved earlier in the individual's career, they may have reached a level of competence to commence the role at around level 3 or level 4. With experience gained in the role, together with ongoing training, this may rise to level 6 or even level 7.

3.7 The T.A.P. model summary

This chapter has explored the rationale and development of the T.A.P. model, with thoughts and actions both contributing towards professionalism. The T.A.P. model structure and use within this study have also been discussed together with a consideration of uses within hypnotherapy and more broadly.

The next chapter 'Methodology' (chapter four) will explore the research paradigms and methodology, detailing how the survey research of questionnaires was conducted as well as exploring issues surrounding rigour, reliability and validity together with ethics and data management. Participants are described, together with a discussion relating to the materials and procedure applied. These are then explored and discussed in detail in the Data Analysis (chapter five) and Discussion (chapter six) chapters, leading to the Final Conclusions and Recommendations (chapter seven).

4. METHODOLOGY

4.1 Introduction

As has been previously observed in the Introduction (chapter one), Review of Literature (chapter two), and T.A.P. model chapter (three) the aim of this research is to conduct an analysis of the influence of the H.NOS upon hypnosis (creating the state of hypnosis and associated phenomena) and hypnotherapy (therapy utilising the hypnosis state and associated phenomena) teaching and learning, and professionalism in the United Kingdom. The direction of the research was focused by the experiences of the author, during her training and ongoing development as a clinical hypnotist. The hypnotherapy world is broad, diverse, eclectic and, particularly in the UK, appears divided between medics, academics (researchers) and lay practitioners. Only the latter group is the focus of specific, albeit voluntary self-regulation. However, for all hypnotists and hypnotherapists, the extent of initial and ongoing training varies considerably. The NOS and specifically the H.NOS set a level for skills, knowledge and understanding, with the associated Core Curriculum specifying minimum educational standards in terms of theory and practical application of techniques. Practitioners whose training meets the H.NOS are able to register with the CNHC who are the voluntary self-regulation (VSR) body. However, a survey of the literature did not locate any research analysis on the influence of the H.NOS on either teaching and learning for those entering or developing within the profession, or the professionalism of those operating within the profession.

Within the diversity of the hypnotherapy profession, it was identified that there are four key groups of influence, as seen in the Review of Literature, and this research will focus on: professional bodies, educators, researchers and practitioners. The professional bodies have a role in directing the profession in terms of setting professional competence standards and educational standards for new practitioners and the ongoing practice and development of professional practitioners. Some organisations are broad in terms of membership, such as the General Hypnotherapy Register, with a mix of medical, academic and lay practitioners, whilst others, such as the British Society of Clinical and Academic Hypnosis are much narrower. The educators will work with the

standards and criteria set by the professional bodies, together with their own standards and criteria to provide both initial and developmental training. Similar to the professional bodies, some educators may attract a wide range of students, including medical practitioners, academics and lay practitioners, whilst others are more targeted, perhaps recruiting those interested in a particular aspect of hypnotherapy, such as the use of Ericksonian approaches. Both the professional bodies and educators will inform and contribute to the development of professionalism within the profession by working with those within the profession. The researchers (academics) tend to be from a psychology trained background and their understanding of and experience within clinical practice tends to vary. Finally, the practitioners, who enter the profession usually after initial training and may work in diverse roles from sole practitioners in private practice through to working in a multi-therapy approach in healthcare environment. The methodological approaches selected need to be able to sufficiently capture data from all four groups, which are different in their compositions, with practitioners and researchers responding as individuals, and educators and professional bodies responding on an individual basis yet representing their organisation.

Cohen et.al (2004:44-5) consider that "*...the aim of methodology is to help us understand, in the broadest possible terms, not the products of scientific inquiry but the process itself."* Holtom and Fisher (1999:35) talk of methodology being the recipe by which the research is carried out. Thus, for this research, a flexible recipe is called for.

To investigate the influence of H.NOS on hypnosis and hypnotherapy teaching and learning, and professionalism a range of methodological approaches may have been employed, each with their merits and disadvantages and these will be discussed. Thus, a number of choices were necessary during the progress of this research regarding the methodological approach, methods and instruments. Justification for these choices can be found within this chapter.

Firstly, this chapter offers an overview of the paradigm selected, together with reasons for rejecting other key paradigms. This is followed by a discussion of research methodologies and the argument that is made for the utilisation of a combined deductive and interpretative approach. Subsequent elements within this chapter consider the argument for the use of the survey approach and selected instrument of online

questionnaire. Topics of rigour, reliability and validity are then explored before providing an overview of the participants, the relevant materials and procedure taken, prior to a discussion on data management. This chapter concludes with the topic of research ethics. Throughout the chapter, and the study, the defining research paradigm offers direction and focus.

4.2 Research paradigm

The selected paradigm

Denzin and Lincoln (2003:256) suggest a post-positivism approach ontology (the kinds of things that exist) has 'real' reality, but only imperfectly, with an epistemology (whether and how we can know anything) where the findings are 'probably' true, and where falsification of hypotheses is possible, methodologically, although qualitative, interpretative, methods may be included. Building blocks of knowledge are accumulated and the criteria focus on rigour, reliability, validity and objectivity. A post-positivist paradigm, according to Burgess *et al.* (2006) is where absolutes are difficult to establish, but still research strives for objectivity, combining qualitative, non-numerical and quantitative (numerical) approaches to data collection and analysis. This paradigm is relevant for this study, which takes an objective, deductive, normative view of subjective responses (Cohen *et al.*, 2000:35) with the use of questionnaires, predominantly asking quantitative questions, together with comment boxes enabling an interpretative view of subjective responses.

The rejected paradigms

The 'strictly scientific' positivism paradigm was considered and rejected as being unable to provide the richness and depth of personal and professional opinion. Burgess *et al.* (2006) consider positivistic approaches assume certainties and reliable facts, using quantitative statistical methods to provide objective scientific knowledge and testing hypotheses against empirical data. For this research though, individuals opinions are sought, thus the data will not be numerical. Some types of non-numerical data, such as clearly factual data (for example 'yes' and 'no'), can be categorised and transformed to numerical. However, it was anticipated that the data would be more towards opinion and less towards discrete facts, thus not appropriate for this type of transformation. Consequently, a positivist approach was not appropriate for this research. This is

supported by the view of Wright (2004:17) who suggests that critics who argue for positivistic approaches consider people as 'little other than numbers' and this research is about knowledge, experience and perception.

In contrast to the 'scientific and logical empirical approach of positivism (Cahoone, 2003), interpretivism, according to Burgess *et al.* (2006) offers no absolutes at all. Here, phenomena can be studied and interpreted in different ways as people and situations differ and realities are not abstract objects but dependent on the inter-subjectivity between people. The interpretivists consider human beings attribute meaning to or interpret phenomena under investigation. For this study, a singularly interpretivist approach was rejected as a more wide-ranging objective study of specific points relating to training, learning and professionalism, in qualitative form, was desired to gain triangulations of data.

Another rejected paradigm is that encompassing critical, constructivist and feminist approaches. Burgess *et al.* (2006) suggest this approach does not accept the socio-political status quo, but seeks to challenge in relation to gender, racism, power and oppression. In doing so, it provides greater understanding and an explanatory framework of inequalities, arguing that researching is an active process, in which researchers construct new ideas or concepts based upon their current and past knowledge. Furthermore, Dawson (2009) suggests feminist inquiry is both a methodology and an epistemology. With an emphasis on participative, qualitative inquiry, it offers a framework for researchers who do not wish to treat people as objects (Dawson, 2009). Whilst this is in opposition of the positivist approach of treating people as numbers, it is not the intention of this research to focus on the areas this approach excels in challenging. Rather, this research is of a more factual nature with no particular aim to explore issues from a gender, race or oppressive perspective, nor from a 'person as an object' perspective (feminist). Whilst it could be argued that the H.NOS is a government initiative with 'power' over the relevant parties affected, this study is directed towards the 'influence' of the H.NOS, not the 'intention' of the government or any other parties.

Also considered, and rejected were approaches such as grounded theory (Glaser and Strauss, 1999). It was not anticipated that there would be any need for generation of

theory. With this approach, the theory is grounded in the data that has emerged from the data, continuing with data collection until 'saturation' reached, where no new data emerges. Again, this research has a more factual direction focusing on the 'influence' as opposed to any theory of the H.NOS, and these influences will be ascertained from surveying the four groups identified for their facts and perceptions.

4.3 Research methods

Quantitative and qualitative

This study took a predominantly quantitative approach. Swetnam (2000) considers quantitative research focuses on the objective, the physical, the external world with universal rules and laws (H.NOS for example) and testing of hypotheses with experiments and surveys, contrasting with the subjective, qualitative approach, which observes and explains groups and individuals.

Whilst, as can be seen in selected research tools, the questionnaires are of a quantitative design, there was a deliberate inclusion of text-based 'comment' boxes to elicit respondents' qualitative views. Goodwin (2004:21) suggests qualitative approaches enable research into people's beliefs, actions and values, placing meanings of activities into their appropriate social context. Burgess *et al.* (2006) consider qualitative researchers often see themselves as the primary instrument for data collection, interacting closely with their subjects, whilst quantitative researchers avoid influencing the collection of the data, staying detached from their participants. With large-scale quantitative research, generalisations across groups of people can be made. With qualitative research, for this study (questionnaire comment boxes), each school, individual (practitioner or researcher) or professional body culture is likely to have idiosyncratic set of values and beliefs, with generalisation more difficult. Newman and Benz (1998) suggest qualitative and quantitative are not polar opposites, rather they are at different ends on a continuum, with mixed methods in the middle.

Robson (2007:21) suggests it is increasingly recognised that such 'absolutist' positions between qualitative and quantitative camps are unhelpful. Furthermore, Hammersley (1996) considers a multi-strategy research can be valuable and offers triangulation, where two strategies or approaches, such as qualitative and quantitative, provide results

that can be checked against the other, facilitating access to findings otherwise unavailable.

Cohen *et al.* (2000) support the separation of research paradigms. However, Merton and Kendall (1986) suggest a combination of paradigms makes use of the most valuable aspects of each, although they do recognise the challenge of selection of contrasting features from each also. Cohen *et al.*'s, description of 'normative research' being objective, conducted 'from the outside' and of technical interest, does appear to describe the aims of this research, the richness that interpretative approaches give, with a balance with subjectivity, and being of practical interest can only add to the depth and richness of the data. Furthermore, the balance of 'generalising from the specific' to 'interpreting the specific' is considered to further add depth to the work. Thus it can be considered that the inclusion of comment text boxes in the questionnaire enables both quantitative and qualitative perspectives of respondents.

4.4 Survey research approach

Survey approaches enable collection of data for a large number of cases and, by their design, are an appropriate method for systematic and comparable data collection. Using questionnaires which combine both ~~with~~ quantitative and qualitative responses can be considered to add rigour, depth and breadth to the overall research design. Swetnam (2000) considers surveys can be descriptive (recording the quantity that agree or disagree) or explanatory (recording why they agree or disagree). Given the unique nature of this research, in terms of subjects and its seeking of factual and perceptual data, no previous surveys were found to replicate in terms of overall design or specific questions. However, whether using a 'tried and tested' survey would offer any true benefits is debateable, as Aldridge and Levine (2001:5) point out each survey is unique. Due consideration has been given to the selection and design, to reflect Clough and Nutbrown's (2002) observation which suggests that the channels of communication selected for the research determine what will pass along them.

Questionnaire approaches

Robson (2007) suggests that the fixed design of questionnaires is advantageous as it is possible to predict the time and resources required to collect the data, that they can be

used for large samples and, with representative samples, is generalisable. This is an ideal approach for this study which aims to reach large numbers across the four groups. However, deficiencies in sampling or low response rates can lead to misplaced confidence in the results and it can be difficult to assess the seriousness or honesty of response, particularly if respondents have been given incentives, consequently the exact approach must be carefully planned and prepared.

Bryman (2001) suggests, for 'self-completion questionnaires' that good design can aid completion rates, regardless of the means of distribution, whereas a poorly organised design may increase question skip rates or even increase dropout rates, due to confusion or frustration. Furthermore, it is important to avoid ambiguous questions or styles of language that respondents are unused to and consider carefully the use of closed and open- ended questions. Closed questions are quicker to answer, easier to code and analyse, have a predefined response, with no new issues, yet can easily frustrate respondents if the options don't match their preferred response (Bryman). Therefore it is vital to ensure that there is offered an appropriate range of potential answers. Open questions can lead towards a qualitative response and can be used to further explore closed question responses (for example by asking 'why?'). Although open questions can be slower in completion time, they do not stifle response in the same way as a closed question might. Brace (2004:55-62) suggests they are useful when seeking opinions, feelings and attitudes. It would appear beneficial to include a range of open and closed questions depending on the type of answers sought. Furthermore, whether open or closed, care is taken to ensure the wording avoids leading the responder, both in terms of the question posed, and the answer choices offered, such as having three of the five options as positive. Hence the central option is skewed towards positive. Thus to avoid bias, a balance of options is advisable (Brace, 2004:81). Moreover, it can be advisable, for some questions, to consider the use of 'not-applicable' for occasions where the question does not relate to their circumstances, as this can maintain completion rhythm and, according to Iarossi (2006:61), increase both the response rate and quality of the collected data. This can offer clarity by providing a definite answer as opposed to leaving investigators wondering what their response may have been if the respondent simply skipped the question.

Questionnaires can be considered inexpensive to administer and distribute, particularly if done electronically, and thus useful for geographically dispersed samples and convenient for respondents. Furthermore, they can be perceived to benefit from the lack of 'interviewer effect' on the data such as bias in terms of gender, ethnicity, or age, with no variability in how the questions are asked. However, additional data cannot be subsequently collected, particularly with anonymous respondents, and asking a large amount of questions can reduce response rates as respondents get tired or frustrated, potentially quitting the survey or leaving some questions unanswered. There is also a risk of prestige bias and social desirability bias, leading to a need for sensitive questions to be asked indirectly. Piloting the questionnaire can assist with identification of any such bias and aid clarity of expression generally. Although, anecdotally, response rates seem traditionally low for questionnaires, measures can be taken to optimise results, including ensuring questions are relevant to the respondents (hence the four slightly different questionnaires in this study), that clean, unambiguous language is used throughout, the questionnaire has clear instructions, is pleasantly presented, well constructed and clearly laid out, and offers a completion progress bar. Greetham (2001) talks of writing persuasively whilst avoiding leading or bias. There can be considered some researcher influence in consideration of their involvement in the determination of the question wording and presentation, together with the selection of question option answers for closed questions.

Lester and Lester (2006:34) consider it important for the researcher to understand whether they are measuring: attitude, knowledge, skills, goals and aspirations, behaviour, or perceptions, as this can influence the design and structure of the questionnaire. Further to this, Bell (2005) suggests that the more structured a questionnaire is, the easier it is to analyse. She goes on to recommend avoiding ambiguity and imprecision and the necessity to avoid assumptions. Of particular relevance to this research is the influence of memory and relevance. The original H.NOS were launched in 2002, thus participants may forget whether they were initially aware of the NOS at the time. Furthermore, some respondents may not have entered the profession until after 2002.

Interview approaches

Although questionnaires were the selected method of data collection, the use of interviews was considered and ultimately rejected, considering that a larger quantitative sample would provide a better representation of the perceptions of the four groups. Furthermore, initial preliminary enquiries indicated a reluctance of individuals to participate in in-depth interviews of the type necessary to address the research questions. Nevertheless, a broad range of interview approaches were explored. It is acknowledged that although interviews provide information, reveal and explore attitudes, behaviours, experiences and in-depth opinions, the questionnaires offered a more factual perspective. Burgess *et al.* (2006) suggest that the social construction of events or phenomena that emerge are constrained by the circumstances in which the interview has occurred. Furthermore, they consider interviews are unique and context-specific, and this is both the advantage and disadvantage of the interview as a research strategy. Beyond social construction, Goodwin (2004) considers interviews are social activities, and that the social dynamic is relevant, suggesting selection of the sources that will provide the most relevant information. In support, Bradburn *et al.* (2004), view the interview as a special case of ordinary social interaction, with conversations structured by a set of assumptions that help the participants understand each other without having to explain everything that is meant. However, it can be questioned whether the interviewer is truly ever without bias or influence, as it is their understanding of these assumptions that interprets and communicates. It is suggested by Burgess *et al.* that the interview questions start with the easiest, to put interviewees at ease, and that these questions are open-ended, to enable interviewees to understand early on in the interview that the interviewer seeks their views and opinions. For Grice (1975) interview conversations are co-operative in nature, yet there are potentially wide ranges of conscious and subconscious influences upon that co-operation, including social-desirability bias. For practitioners and researchers, this social-desirability bias may take the form of a desire to appear informed, or to share their political philosophy, yet for educators and professional bodies, their bias may be more about maintaining or disseminating their organisational philosophy. Bingham and Moore (1959) consider the research interview is more of a 'conversation with a purpose' and for Bradburn *et al.* (2004) the interview survey is a transaction where, according to Ball (1993:32), researchers must "charm the respondents into cooperation". This would seem to link to

Greetham's (2001) concept of persuasion as earlier mentioned or even raise questions about coercion.

An interview may be regarded as a purposeful elicitation of specific information from a respondent (Moser and Kalton, 1971:271). Bell (2005) suggests that one of the advantages of interviews is their adaptability, with the opportunity for responses to be clarified and expanded upon. Wiseman and Aron (1972) who support such a view, regard an interview as a 'fishing expedition' and Cohen (1976:82), also on a fishing theme, consider planning, preparation and patience are similarly required for interviews to then be rewarded with a good 'catch'. Perhaps the perceived flexibility of an interview also allows the potential of bias to occur unobserved. Selltiz *et al.* (1962) and Bell (2005) do suggest the interviewer may have an effect on the respondents, with the perception of what is fair and unbiased changing from individual to individual (Bell and Opie, 2002) whilst differentially weighting information and observing only part of the data presented (Miles and Huberman, 1994:253).

Semi-structured interviews appear to be common in qualitative social research as they offer more flexibility than structured questionnaires, enabling further 'drilling down' yet also offer some structure to keep focused on the intended direction. Dawson (2009) suggests the researcher looks for specific information that can be compared and contrasted with information gained in other interviews, as the same questions are asked in each interview, retaining flexibility to allow other important information to arise. However, the use of an interview schedule (list of questions) ensures continuity.

Unstructured interviews could certainly provide larger and broader amounts of data yet be more related to life history and in-depth explorations of intimate life information which can be difficult to analyse (Dawson, 2009) and not as relevant for this study. In addition, the formal structured interviews, where the participant is subjected to a series of questions with tick box answers, almost similar to a verbal questionnaire are not appropriate for this research. This would gain little new data, nor efficiently triangulate the questionnaire data. Group interviews were also not considered appropriate. These can be time-saving initially, and useful for gaining information on a range of perspectives, particularly observing changes during the progression of a discussion, and noting individual perspectives. However, such progression of discussion and associated

insight or viewpoint changes are not sought for this research. Moreover, although it is possible to gain many responses, some participants may be shy to come forward, or have their views contaminated or inhibited by stronger individuals. However, it would be impossible to maintain individual confidentiality.

As has been observed, semi-structured interviews would have offered the most appropriate approach if questionnaires had not been selected. However, it is recognised for any potential future research that considerable additional resources, particularly in terms of time, would be required, for the initial interviews, compiling the transcripts and qualitative analysis of the data.

Online survey approaches

There are advantages to employing online survey methods as opposed to paper questionnaires, particularly where evaluation of training or teaching related matters is concerned (Hastie and Palmer 1997, Dommeyer *et al*., 2004, Salmon *et al*., 2004) and is considered by Watt *et al*. (2002) to offer time saving from a data entry perspective. It can also be considered beneficial from a data accuracy viewpoint. However, according to Richardson (2005) in a review of literature regarding online instruments, little is known about response rates for online surveys. Nulty (2008) disagrees, suggesting though that there is 'substantial variability'. Furthermore, Nulty considers online surveys are likely to receive a lower response rate than a paper survey and reports a review of eight surveys which overall indicate a 23% lower rate. Watt *et al*. (2002) research is perhaps an exception as their online survey rate was 32.6% and for paper surveys it was 33%. However, Nulty argues that as Watt's research was with those who had learned via distance learning and it can be seen how this could explain the difference, as the respondents were used to responding online.

Factors that may boost online survey responses include repeating the email or sending reminders and offering incentives. Ehrmann (2004) considers such incentives as 'extrinsic motivators' and warns they may bias the sample towards those who respond to such motivation. Instead, it is suggested that to gain 'thoughtful participation' it is important for respondents to understand the survey is worth their time. However, it would appear (Nulty 2008) that such methods of reminders and incentives can notably increase response rates. Nevertheless, Kittleson (1995) and Cook *et al*. (2000) warn of

the risk of irritating or frustrating the surveyed population. The source of the reminder can have an influence with Zúñiga (2004) suggesting reminders from academics useful for students. Thus, for this research, it could be seen to be reminders from educators and professional bodies, as opposed to directly from the researcher, may be more positively received. Quinn (2002) offers a range of strategies that can be used to gain high response rates to online surveys. One such suggestion is that the longer a survey is available, the higher the chance of completion. Although, here it can be seen that the reminders Zúñiga suggested would be beneficial. It could be considered that indirect reminders were used as professional bodies and educators were asked to re-send their initial information to their members, students and graduates. It is acknowledged that where practitioners and researchers hold membership with more than one organisation, there may have been duplication of receipt of information as each professional body disseminated the information about participation in the study.

4.5 Rigour, reliability and validity

When considering research methodology, several questions may be asked about the research, ascertaining whether the approach addressed the following: valid and reliable, precise and accurate in relation to quantitative aspects and depth to the qualitative elements, and with whether it measured or described what it was intended to and whether the findings were generalisable. All of these questions were asked and then answered by the research design.

When considering the reliability question of whether the same procedures carried out again would produce the same result, precise measurement of the dependent variable is considered to enhance reliability (Field and Hole, 2003) which starts with accurate definition of what is being measured and continues through the research study. In addition, this may enhance reliability, although it does not guarantee it. Robson (2007) considers that even using standardised methods of collection such as a questionnaire, whilst more likely to be reliable, can still obtain different answers at different times due to what is going on in the respondent's life at the time. The questionnaires were available to answer for a period of nine months, and thus had there been any notable changes in the profession, such as a new regulatory body (there was nothing relevant) then the questionnaire reliability may have been influenced.

Cohen *et al*. (2004) seems to ask deeper questions of validity in research, including whether validity is found with honesty, depth, richness and scope of data achieved, participants approached, the extent of triangulation and, or the objectivity of researcher? It would appear Swetnam (2000) concurs, suggesting that concepts of reliability, validity and generalisability are not exclusive to the quantitative researcher. Rather, the qualitative researcher must strive to overcome the "*unjustified belief*" (Swetnam, 2000:29) in the lure of numbers and the perspective that measurement is more valuable than observation or description. Hammersley (1992) and Cohen *et al.* (2004) both consider validity is relevant to both qualitative and quantitative methods and, according to Sapsford and Jupp (1996), relates to whether the design of the research produces credible conclusions. This is relevant to this study, as there will be an element of qualitative response, in terms of completion of 'comment' text boxes. How those boxes are placed may influence what is written and care should be taken that their use and relevance is specific and accurate.

Whilst there are many common threats to internal validity which are not relevant to this study, particularly those relating to experimental studies, such as regression to the mean, instrument change and maturation (Field and Hole, 2003), there may be a risk from an external event causing a change in participants' perception during the time that the surveys are open for response (May 2012 to January 2013). For example, those completing the survey in May or June may be 'pre-announcement' and those in July to January might be 'post-announcement' for an announcement directly influencing the perception, content or action or the H.NOS, such as the launch of an amended version. Threats to internal validity may also be considered in relation to the restricted numbers of participants, which can affect both reliability and the ability to generalise to the population. Furthermore, Campbell and Stanley (1963) consider external validity and generalisability are synonymous, yet Mook (1983) disagrees, theorising that they are not the same.

Meltzoff (2010) suggests the significance of generalisability varies according to the intent of the research. For example in 'existence' research, one black swan would prove the existence of black swans. Several factors can be considered from a generalisable perspective. Firstly whether the results would apply to others in the same group, such as other hypnotherapy practitioners additionally whether another researcher or another

setting (location) would obtain the same results. Thirdly whether the results are time bound. This may be of significance due to the duration of the questionnaire being available for a lengthy period, in this case 9 months due to the initial low numbers of respondents. The final factor relates to the instruments applied. It would seem foreseeable that other instruments apart from questionnaires and surveys would obtain different data. However, how different would be the key factor in determining generalisability? For example, focus groups or group interviews may provide more data due to the development of the discussion amongst the participants, or, it may obtain less data from some of the participants who deferred to the perceived more experienced of knowledgeable in the group. Data from interviews may rarely be considered generalisable because they are about feelings, attitudes and individual life experiences.

The extent to which the work is generalisable to the influence of other complementary, alternative and psychological therapy NOS, upon the teaching, learning and professionalism of other therapies is of interest. It certainly would benefit from further investigation. It could be considered that it would be more relevant to a talking therapy, such as counselling, and perhaps less relevant to a physical therapy, such as massage. As hypnotherapy is an eclectic talking therapy, drawing on many psychological and psychotherapeutic theories and methodologies, it can also be argued that aspects of other talking therapies will fall within the scope of hypnotherapy and thus, the work is generalisable. However, this could be countered with the suggestion that hypnotherapy has a more varied history, as discussed in the Review of Literature, and dispersed contemporary perspectives, more than any other talking therapy. There are no entertainment forms of psychotherapy or counselling for example. Although, it may be suggested that with the popularisation of therapy in the media, and television programmes focusing around therapy, the focus of the population is still upon therapeutic outcomes, rather than ‘dancing with a mop and imaging it to be Madonna’ as could be expected with a hypnosis stage show, or ‘falling under the spell’ of entertainers such as Derren Brown. Beyond such issues and those relating to reliability and validity, Field and Hole (2003) consider that in addition to reliability and validity, any study should have importance, although it would seem (Sidman, 1960) that what is important will change over time.

4.6 Participants

The population and recruitment of participants

The study sought to survey a sample from the population of qualified hypnotists and hypnotherapists practicing in the UK, together with researchers who use hypnosis or hypnotherapy, educators (training schools for hypnosis and hypnotherapy) and hypnosis and hypnotherapy professional bodies.

As has been explored in the Review of Literature (chapter two), the population of the hypnotherapy world in the UK is diverse, with practitioners ranging from 'hobbyists' and those using hypnosis for entertainment purposes, through to part-time and full-time practitioners. The latter are mostly based in private work. The researchers in the population may come from psychological and science backgrounds (as gleaned from internet searches and research articles published), as opposed to hypnotherapists. The educators range from therapists who teach an occasional workshop, through to organisations with external validation or accreditation. The professional bodies range from those established for the graduates of specific training organisations, through to large organisations that offer membership to a wide range of therapists who meet a specific standard.

Although the H.NOS are not directly focused on the hypnosis researchers, all the other three groups are directly connected to the H.NOS. It could be considered appropriate for those conducting research into and using hypnosis and hypnotherapy to at least meet the minimum standards required by practitioners as much hypnosis and hypnotherapy related research would inform practice, perception and professionalism, whether directly or indirectly.

Participants were recruited, over a nine-month period, using email 'requests for participation' (Appendix A8) and were selected using volunteer sampling (Glatthorn, 1998). However, following commencement of the recruitment process, a snowball sampling effect (Dawson, 2009) was observed, with participants recommending the study to their colleagues.

All requests were via email and a standard format 'call for participation' was adapted for each group or recipient. This included the survey links. For practitioners, the link to

the questionnaire was distributed via the regulatory body, professional bodies and schools to their members and students / graduates, with the consent and permission of the organisation concerned.

For researchers, the link to the questionnaire was circulated to all UK universities with a request that it be circulated to all researchers whose research involved hypnosis or hypnotherapy. It was also directly emailed to a number of individuals, following consultation of recent journal articles published in past sixteen years (the duration governed by access to such journals).

For educators, whether small or large training organisations, in addition to the professional and regulatory body announcements, there was an emphasis on direct e-mail, after consulting lists of schools on professional body websites and links from regulatory body websites and internet searches.

In a similar way to educators, professional bodies were approached both broadly from other organisations' announcements and via direct e-mail, after consulting lists of professional bodies linked from school and regulatory body websites and internet searches.

Sampling methods

It was not anticipated that relatively low numbers of respondents initially would arise from the requests for participation and thus there was a widening of requests to organisations. On reflection, offering an incentive 'prize draw' may have generated more responses, although the quality and honesty of the responses could then be questioned. Had there been a vast response, then it would have been possible to apply some post-completion probability sampling, whether random, by cluster or quasi-random/ systematic, following a pattern after an initial random selection. A stratified random sample would be possible for sampling within the four groups of respondents, particularly as it was anticipated the highest number of responses would be from practitioners and the lowest from professional bodies.

This study used all generated responses, thus using non-probability, direct, self-selected volunteer sampling (Meltzoff, 2010) of those who were in receipt of emails from

professional bodies, regulators and educators. However, it could be considered there may have been some influence of network sampling (snowballing), with the questionnaire being passed on to colleagues and associates (Robson, 2007).

Inclusion / exclusion criteria

The initial participant selection criteria was limited to seeking adult volunteers, over aged 18, capable of giving informed consent to participate in the study. No vulnerable adults were anticipated, given the nature of the enquiry. As neither ethnicity, social category, profession, gender, nor adult age were relevant to interpretation of the data, it was considered that there was no need for positive or negative recruitment in any of these categories for this study.

The sample

The questionnaire sample comprised of 250 adults, comprising 210 practitioners, 15 researchers, 17 educators and 8 professional bodies. As the questionnaires did not 'force' answers (not permit progression until the field was completed), many respondents did not provide demographic information for reporting to be meaningful for the researcher, educator and professional body groups. However, for practitioners a reasonable proportion did complete some demographic data. Practitioner age (n=181) ranged from 28 to 82 years of age (range = 54, SD=10.3), with a 80 males (42%) and 109 females (58%), (gender n=189). Participant ethnicity (n=210) was predominantly British (157, 75%) with 12 (6%) European and 9 (4%) International and 32 (15%) declining to respond. The demographic information did not ascertain whether the respondents had been in practice at the time of the launch of the H.NOS and, with hindsight, this may have been beneficial to the subsequent analysis of the data and is seen as a limitation to the study.

Grouping of data

The questionnaires were retained in their original grouping of: participant, researcher, educator, and professional body.

4.7 Materials

The questionnaire, participant information sheet and consent form were all developed specifically for this study and were piloted and checked for readability and comprehension. These were submitted with the application for research ethics approval (Appendix A9) and University of Greenwich Research Ethics approval was duly received (Appendix A10). These are further discussed in section 3.10.

Call for participation' document

To reach the widest possible audience, ranges of organisations were contacted for their assistance in distributing the 'call for participation' document (Appendix A11). The voluntary regulatory body, the CNHC, and a range of professional bodies and educators were contacted. Researchers using hypnosis were also contacted on an individual basis with names sourced from academic journals, and via emails to UK universities. All organisations received a similarly worded request for them to disseminate the research information 'call for participation' document and were helpful in maintaining the overall message and thus there was a consistent approach.

Participant information sheet

The purpose of the participant information sheet (Appendix A12) was to provide sufficient details about the research study for participants to make an informed decision about whether or not to participate in the study. It gave the project title, information about the researcher, the research and their participation, together with the anticipated benefits, how their data would be treated and what to do if they have any questions.

In the questionnaire, this participant information was presented prior to the questions and thus participants read this and consented before moving forward. There needed to be an appropriate level of detail to ensure the participant had sufficient information to make 'informed consent' Gleitman *et al.,* 2011).

Consent form

The participant consent form (Appendix A13-16) was incorporated into the front section of the online questionnaire. The consent form contained the title of the research and details of the project supervisors, together with several questions focusing on their awareness of what they were giving their consent for.

Participant information section in the questionnaire

The participant information section in the questionnaire (Appendix A13-16), sought participant: name, age, gender, ethnic origin, and date of survey completion. It also sought their contact email and telephone and whether they would be available for interview.

Questionnaire survey

The internet based tool 'Survey Monkey' was selected as the most appropriate research tool for the questionnaire survey. It is operated by a well-established, data secure and technically supported organisation. Although the provider offered a 'free' version, it had advertising and was limited in terms of functionality and number of questions permitted. A range of 'paid' versions were offered and an appropriate version was used to both eliminate advertising and to gain access to a wider range of features. Lester and Lester (2006) consider online surveys useful for large populations and the paid version of Survey Monkey selected had unlimited capacity for respondents.

Although Survey Monkey offered a vast range of pre-formatted questionnaires and standard questions, these were not ideal for the planned research. Furthermore, it was considered that Ethics approval for the questionnaires would best be followed by replicating the wording of the questionnaires to reflect those previously submitted for Ethics approval. The questionnaire was compiled by the researcher, as no established questionnaires were found to ask questions relevant and pertinent to this research.

Responses were sought by selection from a range of response options. Many of the questions were accompanied by a 'Why?' comments response box to seek supplementary, qualitative, views and opinions. The categorical responses enabled consistent data entry into SPSS. There was no scoring or scaling of response required. The specific questions asked within each section of the questionnaire were similar across the four participant groups: practitioner, researcher, educator (teaching organisation), and professional body. However, there were some adjustments to make the questions most relevant to each group resulting in slightly different questionnaires overall (Appendix A13-16).

Pages for each separate topic area divided the questionnaire. It commenced with a welcome and participant information page, followed by the content page. The welcome element was considered important to make the connection with the participant (Lester and Lester, 2006). Then followed topic pages for: awareness of H.NOS, consultation, influence on teaching and learning, influence upon professional bodies, influence upon competence, and influence upon professionalism. The survey concluded with a thank-you page giving the research contact details should they wish for any further information.

Readability of instruments

The questionnaire, call for participation, participant information sheet and consent form instruments used by the participants were examined for readability measures. By keeping the phraseology simple, such as avoiding long or little understood words, the scores indicated 'reasonable' to 'good' levels of readability. Furthermore, it was anticipated that the participants sought were sufficiently educated to understand the material presented.

4.8 Procedure

Survey design and pilot study

An effective pilot study can firm up research questions and methodology when planned into the research from the beginning.

The survey was developed from 'a blank sheet'. This was necessary as this research is the first of its kind, and thus no established questionnaires were available for reference. There are many different ways of asking questions (Robson, 2002). It was considered appropriate to provide a questionnaire of limited complexity to motivate response. Simple approaches such as 'who?' and 'how?' can provide indications of how many respondents hold specific views. Even here the questions should be short and free from ambiguity (Robson, 2002). The questions were written in closed form, with a limited range of responses, such as 'yes', 'no' and 'not applicable'. This was intended to narrow the distribution of responses, as other methods such as Likert scales would have generated. To counter this, comment boxes were distributed throughout the questionnaire.

A pilot study was conducted to assess the comprehension and ease of participant completion of the questionnaires. The questionnaire was piloted to five individuals who have not subsequently participated in the research. The data was observed, to assess it from a validity perspective, and it was found that in general terms it met the purpose intended. Following feedback from discussions with the pilot study respondents, the layout of the questionnaire was changed slightly, to include 'topic pages' and completion progression information bar to enhance the overall presentation. Some respondents considered the questionnaire quite lengthy (although interesting) and in its piloted version they had no idea of how many more questions they had yet to complete, thus the re-design included topic pages and a completion progress bar. Curiously, when the re-design was sent to pilot respondents for comment, not all noticed the progress bar, despite in being large and clear.

Preparation of the environment and participant procedure

As previously highlighted, the questionnaires were completed at a time and location of the participants choosing. During the questionnaire, the participant could work through the process at the pace of their choosing.

4.9 Data management

The participant information, and quantitative questionnaire responses data were entered into SPSS (Statistical Package for Social Sciences) version 20 for data analysis. The qualitative questionnaire data from the comment text boxes were also downloaded from SurveyMonkey and initially located in a Word document, from where they were analysed through a process of manual coding. Dey (1993) suggests qualitative data is first described, then classified, and then connected, to identify similarities between different categories of data, analysing the interconnections and this formed the basis of the approach.

All data were held electronically and in paper format in a secure manner, with consideration of the requirements of the Data Protection Act 1998 and, when the data is disposed of, it will be securely destroyed.

4.10 Research Ethics

Ethical issues

Burgess (1989:2) suggests there are questions to be answered when considering ethics, including what individuals should be told, what data can be collected and how data should be disseminated. Bryman (2001), with greater detail, proposes four focus areas of potential for harm, informed consent, deception and privacy. Perhaps more specific regarding breadth of focus, Burgess *et al.* (2006) consider there are ethical implications from the initial conception of the research proposal and through the selection of research methods, yet Bryman would seem to argue for ethical consideration throughout the entire process.

Although Bassey (1999) suggests researchers should have the freedom to investigate and express their research, Burgess *et al.* (2006) consider that responsibilities arise because of that freedom. Whether researchers within an academic institution have such a freedom is debateable, with school and university policies governing research. It would seem reasonable that research is conducted in a way that does not inhibit future enquiries from other researchers. Furthermore, moral and societal implications and influences may impinge upon the widest of freedoms. It could be considered that by conducting research, a change is put in motion, regardless of the outcomes of the research. Where theories are developed because of the outcomes of the research, Schön (1987) recommends the influences of those theories be considered. Although Bassey (1999) considers educational researchers to have a moral duty to respect the privacy and dignity of their research participants, it could be argued that this responsibility goes beyond that of educational research and to any consequences as a result of the outcomes of the research.

This study had formal Research Ethics Approval from the University of Greenwich (Appendix A10). Key ethical aspects for consideration were around protection of the participants and researcher, including anonymity, confidentiality, the right to withdraw at any time, and the need for informed consent without deception (Gleitman *et al.,* 2011). Identified issues were met by the study design and materials, and with identification and control of foreseeable risks and ongoing dynamic risk assessment and control, which included data storage and management.

Gaining access to participants

There were four groups of participants to which access was required: hypnosis and hypnotherapy practitioners, researchers using hypnosis or hypnotherapy, educators (hypnosis and hypnotherapy training schools), and hypnosis and hypnotherapy professional bodies.

Access to research participants for the questionnaire survey was assisted by the co-operation of the voluntary regulatory body, the CNHC, who disseminated all four links to members on their mailing list via their online newsletter. Requests for dissemination to members were also distributed using the contact details for professional bodies listed on the CNHC register. Using those professional body websites of accredited training schools for contact details, requests for dissemination to graduates were also distributed. A series of general internet searches also located professional bodies and training schools who were not previously contacted and these were approached. For the researchers, a search was conducted of relevant hypnosis research published in the past sixteen years in Contemporary Hypnosis Journal (access for this period available via a professional body) and searches were made for the contact details of these researchers. Where located, the UK-based researchers were contacted individually with requests for participation. General information about the research was provided to these organisations and individuals when approached for their assistance. However, where circulation of the research was made by organisations, it could be seen that such circulation would be deemed an endorsement of the research. It was noted that no organisation appeared to unduly influence their members to participate.

The research process

No incentives, such as a completion fee or prize draw, were offered to participants for completion of the questionnaire, in order to avoid concerns regarding the honesty of responses or whether there had been coercion or potential bias from reciprocity, whereby an individual might feel obliged to give the answers they feel the questioner wants as they have been rewarded for their contribution.

The questionnaire questions were compiled in a way that aimed to avoid potential for physical and psychological harm (Field and Hole, 2003), both in terms of emotional reaction to the wording of the questions and in terms of any potential perspective

changes that may arise from the thinking required to answer the questions. By simply asking a question, it generates thoughts that the individual may not have been generated otherwise. Thus, there is a need to be responsible and leave participants in at least as sound a frame of mind as when they commenced the study (Gross, 2010).

The hypnotherapy sector could be considered small enough to be able to identify 'characters', those with novel or extreme views, their 'professional ideology' by which they have made their name. Thus, assuring anonymity was considered important in the quest to obtain good quality and honest data from the questionnaire. Care would be needed in how that data was reported, particularly the qualitative data, to ensure reporting in a way that would not identify the individual.

The research environment for the questionnaires would be wherever the participant chose to use a computer. The programme 'Survey Monkey' was selected for its effective operation across a wide range of computers, tablets and smart phones. By providing a 'completion amount' update on each page, individuals were able to gauge how far through they were. This can be considered beneficial in longer or larger questionnaires to reduce completion frustration.

Beyond preparation of the questionnaire questions, and control of the research environment, the issue of informed consent was considered. 'Participant information' was provided at the commencement of the questionnaire and participant consent was sought prior to completion of the actual questionnaire questions.

The provision of appropriate debriefing can be regarded as needing to be considered for any research where a participant may be influenced or affected by their participation. Although the questionnaire questions may ask participant to consider and reflect upon their thoughts and perspectives, it was considered that there would be no adverse cognitive or emotional outcomes as a result of this action and thus minimal debriefing would be required. Participants were provided with contact details for both the researcher and the research supervisors (Appendix A13-A16) should they have any questions prior to, or following the questionnaire.

4.11 Methodology summary

In summary, the post-positivist approach informs this research, echoing the strive for objectivity yet also seeking the richness and depth of interpretation of subjective views. The predominantly quantitative survey approach reflects a post-positivist approach, with questionnaires seeking both quantitative (closed question) and qualitative (open comment) responses. The extent to which the work is generalisable was discussed in terms of other therapies and their relationship with the H.NOS and it is recognised that hypnotherapy is unique in its history and current uses. The questionnaires had research ethics approval and were piloted, with minor adjustments subsequently made. The population of the hypnotherapy sector in the UK is diverse, with practitioners ranging from 'hobbyists' and entertainers, through to medical and lay practitioners working in therapeutic environments. Some practitioners are also researchers, although these tend to be academic and from psychological backgrounds, conducting research in laboratory environments. Educators and training organisations range from those just offering simple workshops through to degree courses and professional bodies vary from small single organisation memberships through to the large bodies with widespread membership. These four groups of respondents were contacted over a period of nine months. The resultant data from the questionnaires is held electronically and in paper format in consideration of the Data Protection Act 1998. This data, its reporting and subsequent analysis and discussion can be observed in the next chapter, chapter four.

5. DATA ANALYSIS

5.1 Introduction

Following on from the methodology (chapter four) which explored the process that the data gathering would take, this chapter explores the data resulting from that research. The introduction section offers a summary of the research questions and a summary of the findings, together with a description of the sample and the data analysis procedure, which includes how missing values are addressed and the format followed for data analysis. The first two sections after this introduction (5.2 and 5.3) relate directly to the two research questions, which seek the influence of the H.NOS on teaching and learning (research question one) and the influence of the H.NOS on professionalism (research question 2). The following section (5.4) considers the relevance of supplementary information about the participants, and gives an overview (5.5) of a selection of participants from each of the four respondent groups (practitioner, researcher, educator and professional body). The following chapter (chapter five) provides a discussion of the relevance of the outcomes of this research when considering the issues explored in the Introduction (chapter one) and Review of Literature (chapter two), together with a discussion of relevant methodological (chapter three) issues.

The Research Questions

RESEARCH QUESTION No.1

What influence have the Hypnotherapy National Occupational Standards had on hypnosis and hypnotherapy teaching and learning in the UK?

RESEARCH QUESTION No.2

What influence have the Hypnotherapy National Occupational Standards had on hypnosis and hypnotherapy professionalism in the UK?

Summary of findings

It will be observed that questionnaire survey respondents consider the H.NOS have had a positive influence on teaching and learning. However, practitioners and researchers were generally unaware of whether their training met H.NOS, more so for researchers. Those practitioners aware of H.NOS considered it more important for training to meet

H.NOS. Educators and professional bodies were also more positively focused on the importance for training to meet H.NOS and the use of its criteria for training.

It can also be noted that the surveys found a mildly positive influence on professionalism. Professional bodies were more positive than practitioners and researchers less so, with professional bodies generally considering the H.NOS is located below their in-house standards for professionalism. The perception of H.NOS influence on professional bodies is positive.

For both research questions, awareness or not of the H.NOS was particularly influential in resultant responses, especially for practitioners, with responses generally far more favourable in terms of H.NOS influence for those aware and far less favourable for those not aware. Participant characteristics show that responses indicate the consultation process at draft stage and the launch publicity were limited. Yet, all four respondent groups tended to have membership of professional hypnotherapy organisations and both practitioners and researchers commonly participated in CPD.

The sample

There are four respondent groups: practitioners (n=210), researchers (n=15), educators (n=17), and professional bodies (n=8). Due to low completion rates in the age, gender and ethnicity questions by researchers, educators and professional bodies, presentation of this data would have little meaning. However, with a far lower proportion of missing values (skipped questions) in the practitioner group, there is sufficient data to present.

The mean age of the practitioner group (n=181) is 50.94, with a range of 54 (minimum=28, maximum =82) with a standard deviation of 10.3. The distribution is demonstrated in the histogram below (Figure 5.1).

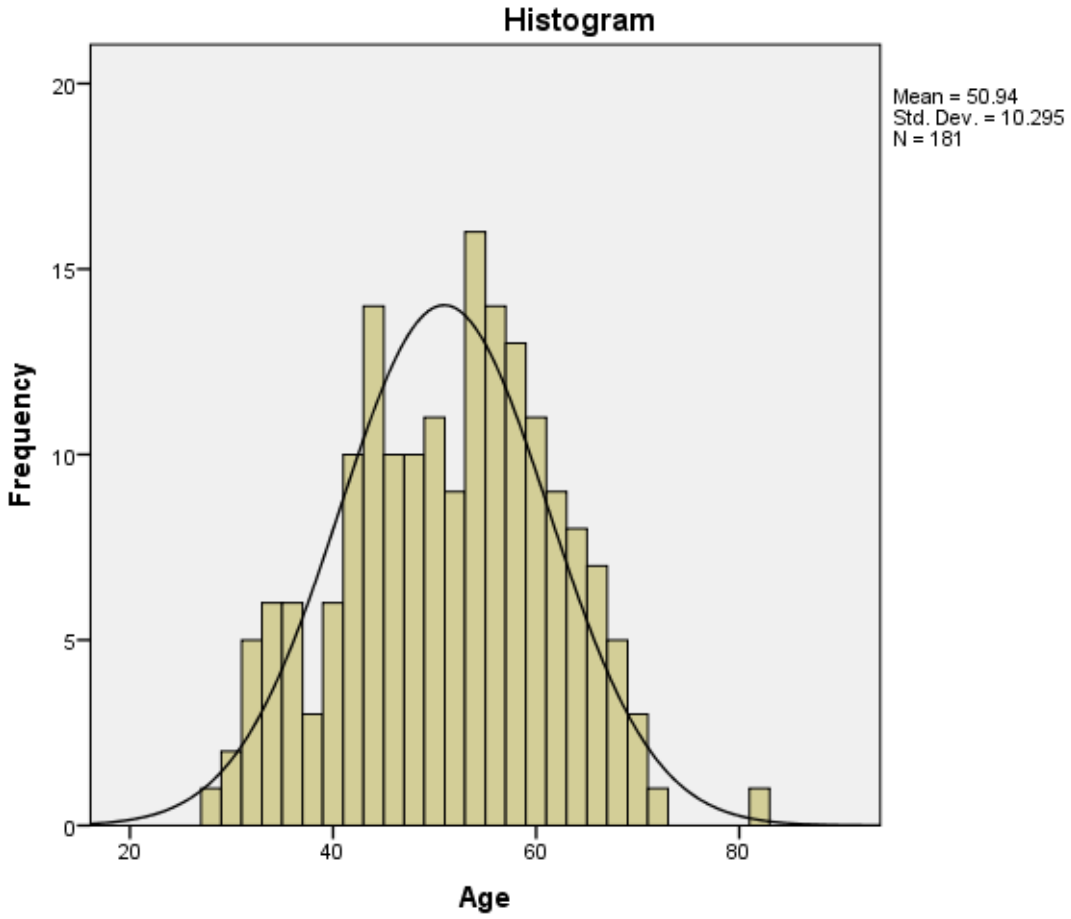

Figure 5.1: Distribution of ages with normal distribution curve

Of the 189 practitioners completing the gender section, 42% (80) were male and 58% (109) were female.

For the practitioners' ethnicity section, it was shown that 75% (157) were British, 6% (12) were European, 4% (9) were International and 15% (32) did not specify ethnicity.

Data analysis

To ascertain the influence of the H.NOS, four groups of participants were surveyed. The resultant quantitative and qualitative questionnaire data is examined. Inferential analysis is conducted, where appropriate, for the practitioner group only, due to the low numbers in the other three respondent groups.

Missing values

It was a deliberate decision in the online questionnaires (using Survey Monkey) not to make use of the 'forced response' facility as, in the pilot study this was disliked by most participants. However, as a result of all of the questions having the option to answer or not, not all questions were answered in some of the questionnaire sections. No calculations to adjust and fill in missing values (skipped questions) were used. Thus, it can be noted throughout these sections that the number of responses for each question varies.

Data analysis format

A number of topics with associated questions from the questionnaire contribute to each of the two research questions. Each of these topics will be reported and analysed separately. The format for analysis for each of these topics is displayed in the list below. Not all aspects will be relevant for each topic, although the same order of analysis is followed.

Order of analysis

1. Overview of the topic
2. Graph
3. Descriptive findings
4. Inferential tests
5. Inferential graph
6. Textual comments
7. Summary

5.2 Influence of the H.NOS on teaching and learning – Research question No.1

5.2.1 Influence on training

5.2.2 Training meeting H.NOS

5.2.3 Importance of training meeting the H.NOS

5.2.4 Use of H.NOS as criteria for standards and training

The most directly focused question in the questionnaire asked about the influence of H.NOS of teaching. This question had three elements: design and content (Figure 5.2), provision and how taught (Figure 5.3) and student learning (Figure 5.4).

As can be seen in the graphs below (Figures 5.2-5.4), questionnaire responses were varied. Practitioners, the largest respondent group, were closely divided in their views between 'no influence' and 'positive influence' in their questionnaires responses, although added comments were more negative than positive, with 37 indicating they did not know about the H.NOS. Researchers generally indicated 'no influence' in the questionnaire survey, with negative comments. Educators' view for all schools, like practitioners, were divided in their views between 'no influence' and 'positive influence', and with textual comments evenly divided. However, professional bodies were slightly more positive in the questionnaire responses. It could be considered that of the four groups, educators' view of the influence on teaching for their own schools is the most telling, as they are those responsible for the design and content of their own material.

On balance, taking into consideration textual responses, it could be considered that practitioners and educators indicate a division between positive and no influence of the H.NOS, whereas researchers are more closely focused around 'no influence' and professional bodies slightly stronger as 'positive influence'. Half of educators consider the H.NOS have had a positive influence for their own organisation and for all schools generally. Three-quarters of professional bodies also considered there to be a positive influence. Individual differences can be explored in more detail by considering the three separate elements of the questionnaire survey question, together with the questionnaire comments.

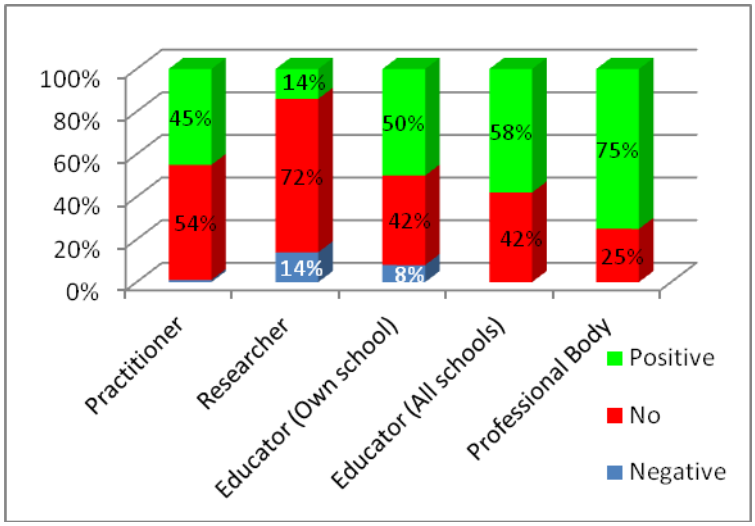

Figure 5.2: H.NOS influence on training: Design and content

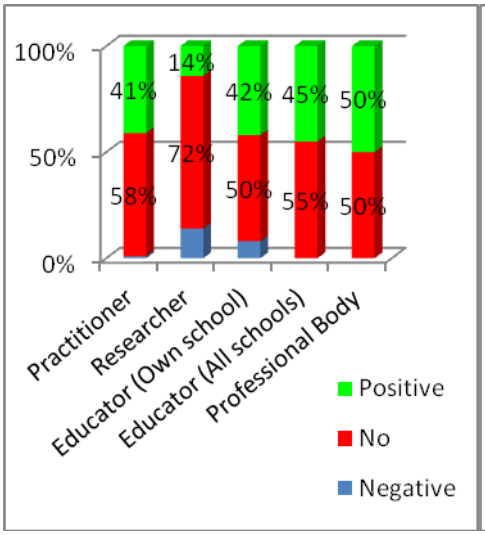

Figure 5.3: H.NOS influence on training: Provision and how taught

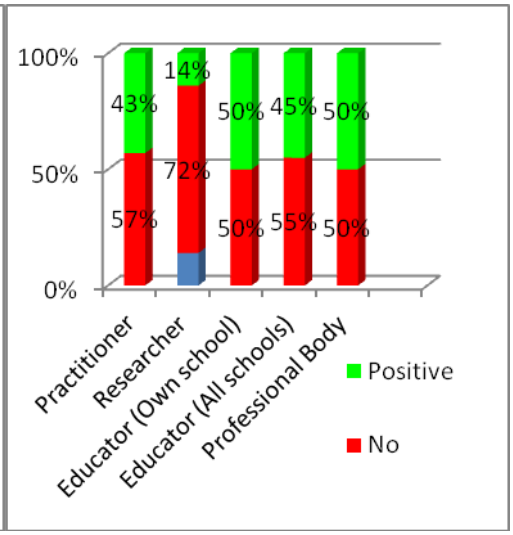

Figure 5.4: H.NOS influence on training: Student learning

5.2.1.1 Influence on training – design and content

As can be observed in Figure 5.2, responses to the question asking of the H.NOS influence on training design and content were divided between 'no influence' and 'positive influence' with 14% (1) researchers and 50% (6) of educators considering them a negative influence. The majority of responses from researchers (n=7) indicated 'no influence' (72%), whereas, educators (n=12, all schools 58%, 7) and professional bodies (n=8, 75%) indicated a 'positive influence' and practitioners (n=153) were divided between 'no influence' (54%) and 'positive influence' (45%).

An analysis was conducted to assess whether awareness or not of the H.NOS would have any influence on responses. A chi-square test was performed with hypnotherapy training design and content responses re-coded to 'positive' and 'not positive'. Some, 23% (*f*=15) of those not aware of the H.NOS (n=64) found it was a positive influence on design and content, with 77% (*f*=49) finding that it did not have a positive influence. This compared with 60% (*f*=52) those who were aware of the H.NOS (n=86) finding it a positive influence and 40% (*f*=34) finding it to not have a positive influence. A chi-square analysis of the frequencies between aware/not aware and the positive/not positive shows a significant difference, χ^2 (1, *N*=150) = 20.36, *p*<.001. The effect size was medium with *phi* = .368 (Figure 5.5).

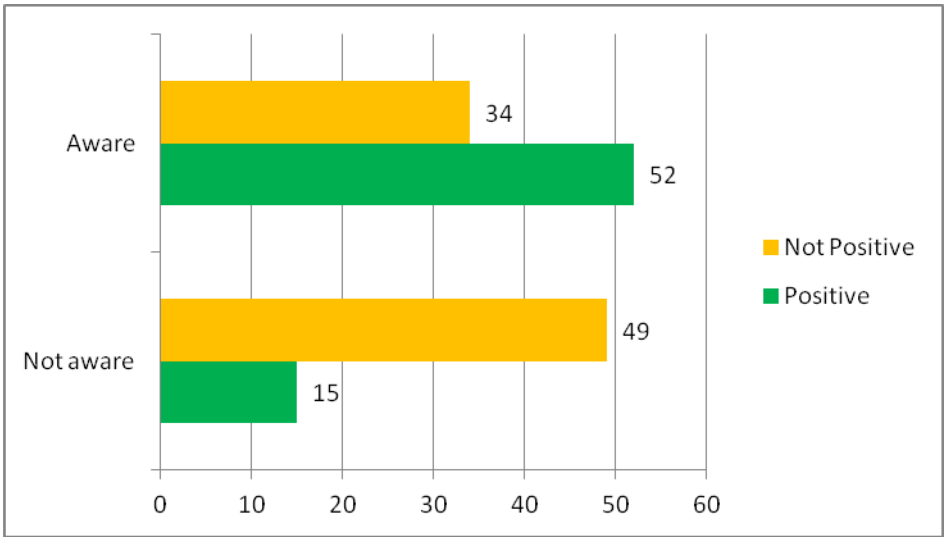

Figure 5.5: Awareness of H.NOS and influence on design and content frequencies of response

5.2.1.2 Influence on training – provision and how taught

Figure 5.3 indicates that most respondent groups' answers to the question on the H.NOS influence on training provision and how taught, were closely divided between 'no influence' and 'positive influence' although marginally stronger in the 'no influence' option, apart from researchers who were focused more strongly (72%) in the 'no influence' option. Practitioners were divided 58% 'no influence' to 41% 'positive influence', with educator's own organisations divided between 50% in 'no influence' and 42% in 'positive influence' and professional bodies were divided 50% in each of 'no influence' and 'positive influence'. There were very few 'negative influence' responses.

For practitioner responses, an analysis was conducted to assess whether awareness or not of the H.NOS would have any influence on responses. A chi-square test was performed with hypnotherapy provision and teaching responses re-coded to 'positive' and 'not positive'. Some 24% (*f*=15) of those not aware of the H.NOS (n=62) found the H.NOS was a positive influence on provision and how taught, with 76% (*f*=47) finding the H.NOS did not have a positive influence. This compared with 54% (*f*=45) those who were aware of the H.NOS (n=84) finding it was a positive influence and 46% (*f*=39) finding the H.NOS not to have been a positive influence. A chi-square analysis of the frequencies between aware/not aware and the positive/not positive shows a significant difference, $\chi^2(1, N=146) = 12.72$, $p<.001$. The effect size was small with *phi* =.295 (Figure 5.6).

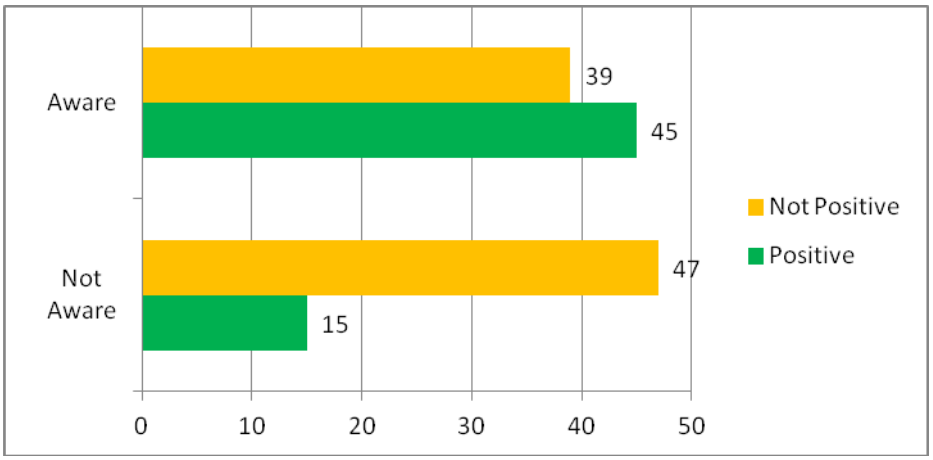

Figure 5.6: Awareness of H.NOS and influence on provision and how taught frequencies of response

5.2.1.3 Influence on training – student learning

As displayed in Figure 5.4, for the question relating to the H.NOS influence of training and student learning, all respondent groups, except researchers, were closely divided between 'no influence' and 'positive influence', with only one respondent (researcher) considering a 'negative influence' (14%). The researchers also were most closely focused on 'no influence' (72%). The practitioners were divided 58% 'no influence' and 41% 'positive influence', similar to educators own school 50% 'no influence', 42% 'positive influence' and educator all schools 55% 'no influence' and 45% 'positive influence'. The professional bodies were divided equally between 'no influence' and 'positive influence'.

An analysis was conducted to assess whether awareness or not of the H.NOS would have any influence on responses. A chi-square test was performed with hypnotherapy provision and teaching responses re-coded to 'positive' and 'not positive'. Awareness or not of the H.NOS and the influence of H.NOS upon hypnotherapy student learning was analysed. Some 25% (*f*=15) of those not aware of the H.NOS (n=61) found it was a positive influence on student learning, with 75% (*f*=46) finding it had no influence. This compared with 57% (*f*=47) those who were aware of the H.NOS (n=82) finding it a positive influence and 43% (*f*=35) finding it to have no influence. A chi-square analysis of the frequencies between aware/not aware and the positive/no influence shows a significant difference, χ^2 (1, N=143) = 15.26, p<.001. The effect size was medium with *phi* =.327 (Figure 5.7).

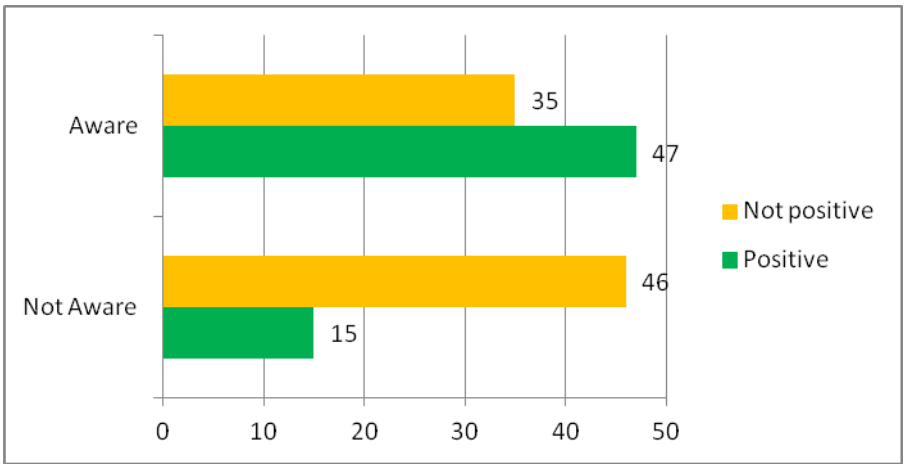

Figure 5.7: Awareness of H.NOS and influence on student learning frequencies of response

5.2.1.4 Influence on training – textual comments from the questionnaires

Overall, over the three questions relating to H.NOS influence on training, there was division between negative (70%) to positive (30%) comments relating to the influence of H.NOS on teaching and learning. The practitioners made 10 comments relating to the H.NOS being 'influential' including *"just because they are National Occupational Standards"* and 'partly influential', mainly relating to selectivity and influence not being "*across the board"*. These were supported by the 9 'not influential yet' comments. There were also 16 positive comments, expressing a range of views about the standards and professionalism and 58 negative comments, including 37 indications of not knowing the H.NOS at all. Researchers responded with a lack of awareness. For educators and professional bodies, responses were evenly divided between positive and negative, including a lack of awareness of H.NOS.

5.2.1.5 Summary of any influence of the H.NOS on teaching and learning

With the questionnaire responses, one-half of practitioners and educators and professional bodies consider the content, provision, teaching, and student learning, apart from design and content where, perhaps unsurprisingly, 75% professional bodies consider it as having had a positive influence. Chi-square tests indicated those aware of the H.NOS found it to have a more positive influence on design and content, and provision and how taught, than those not aware. Questionnaire comments tended to reflect question responses, although there were many indications of a lack of awareness of H.NOS. Overall, it would appear that respondents consider the H.NOS to have had a positive influence on teaching and learning.

5.2.2 Training met H.NOS

Practitioners and researchers were asked in the questionnaire whether their training (from initial to CPD) met the standards of the H.NOS. Generally the majority of practitioners and researchers, for each of the five types of training, did not know whether their training met the H.NOS (Figure 5.8), with the exception of practitioners undertaking initial and practitioner training where the 'yes' and 'unknown' were closely divided.

For initial training, practitioners (n=155) responded that 49% (76) that they did not know if their training met the H.NOS, with 42% (65) indicating it did and 4% (6) that it

did not. For researchers (n=9), 67% (6) did not know and 11% (1), the remaining 22% (2) indicated it was not applicable.

For practitioner training, practitioners (n=159) responded that 48% (77) did not know if their training met the H.NOS, with 47% (74) indicating that it did, and 2% (4) that it did not. Researchers (n=8) responded that 63% (5) did not know, and 12% (1) that it did.

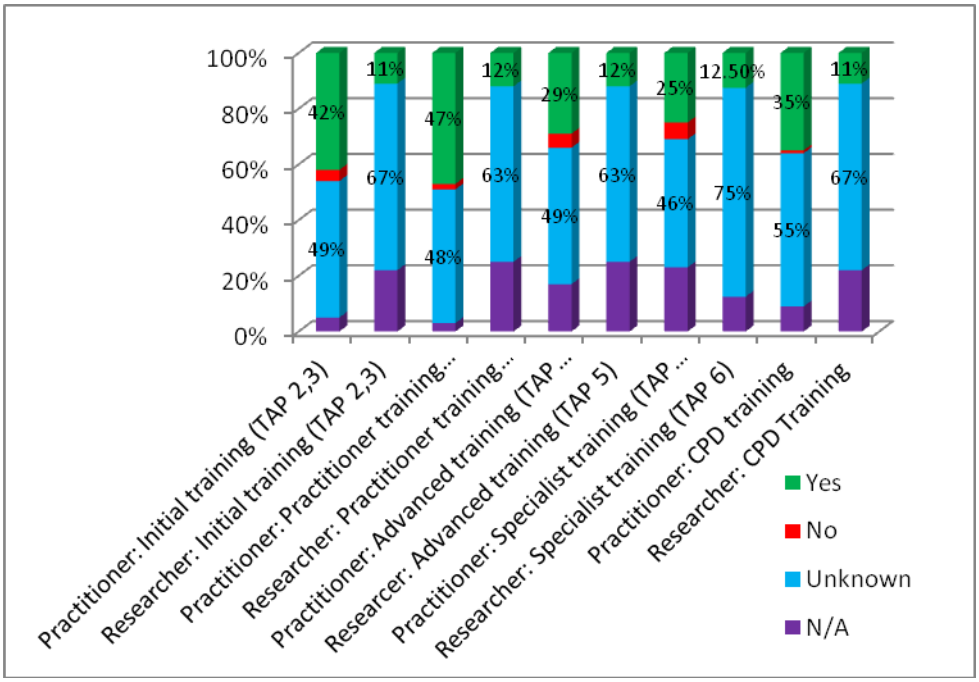

Figure 5.8: Training met H.NOS (all groups)

For advanced training, practitioners (n=123) indicated that 49% (60) did not know if their training met the H.NOS, with 29% (36) indicating that it did, and 5% (6) that it did not. For researchers (n=8), 63% (5) did not know, and 12% (1) indicated their training did meet H.NOS.

For specialist training, practitioners (n=109) responded that 46% (50) did not know whether their training met H.NOS, with 25% (27) indicating it did and 5% (7) that it did not. For researchers (n=8), 75% (6) did not know and 12.5% (1) indicated it did meet H.NOS.

Finally, for CPD training, practitioners (n=136) responded that 55% (74) were unsure whether their training met the H.NOS, 35% (48) indicating that it did and 1% (2) that it

did not. Researchers (n=9) indicated that 67% (6) did not know and 11% (1) responded that it did.

5.2.2.1 Summary of training meeting H.NOS

Generally, practitioners and researchers were unaware of whether their training met H.NOS, although more practitioners than researchers responded that it did and were more aware of whether their initial and practitioner training met the H.NOS than any other training.

5.2.3 Importance of training meeting the H.NOS

All four respondent groups were asked their views of the importance of various levels of training meeting H.NOS. In addition, professional bodies were asked to respond from two perspectives, both as relates to professional bodies themselves and their view on how it relates to educators. Respondents' views differed regarding the importance of their training meeting the H.NOS. For initial training, only researchers did not have a notable 'yes' percentage, being mainly focused in the 'don't know' category, where they were located for all other levels of training also, ranging from around two-thirds to three quarters. For the remaining levels, practitioners had midway percentages in the 'yes' category. This contrasts with stronger percentages in the educator and professional body groups 'yes' category (Figures 5.9 to 5.13).

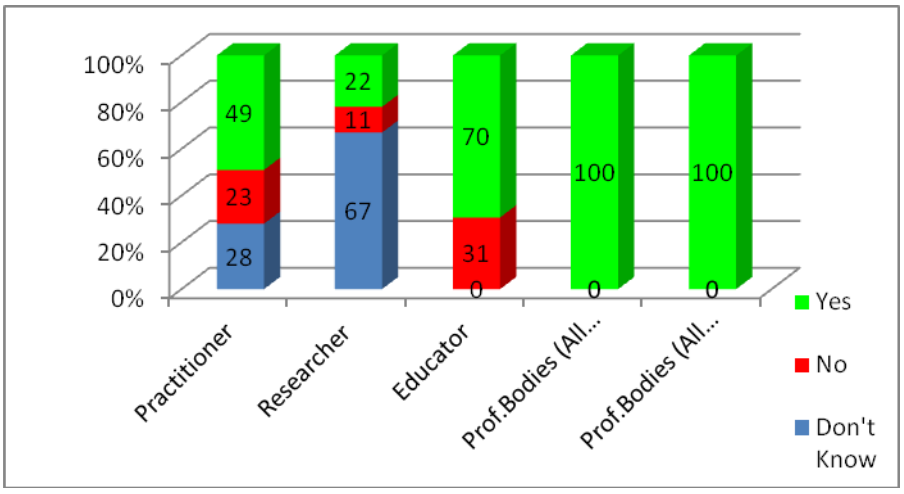

Figure 5.9: Importance of Initial training meeting H.NOS

It can be noted that practitioners (n=168), researchers (n=9), educators (n=13) and professional bodies (n=8) did not answer all questions relating to the training questions.

For initial training (Figure 5.9), just 22% (2) of researchers, 49% (78) of practitioners, 70% (9) of educators, and 100% (5) of all professional bodies considered it was important to meet the H.NOS, with the remainder either considering it was not important, or, for practitioners (28%, 44) and researchers (67%, 6) that they did not know.

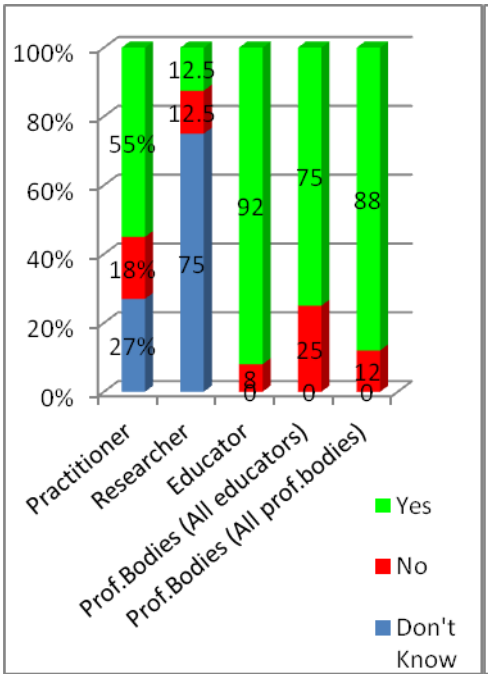

Figure 5.10: Importance of practitioner training meeting H.NOS

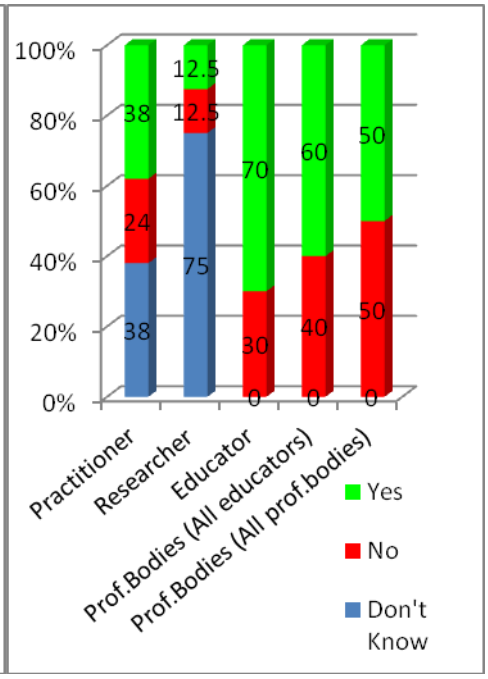

Figure 5.11: Importance of advanced training meeting H.NOS

For practitioner training (Figure 5.10), just 12.5% (1) of researchers, 55% (85) of practitioners and 92% (12) of educators consider it important for the training to meet H.NOS. Opinion of the professional bodies was divided for all professional bodies (88%, 7) and all educators (75%, 6). The remaining responses were located in the 'no' not important category, apart from practitioners (27%, 42) and researchers (75%, 6).

Advanced training (Figure 5.11) was only important for 12.5% (1) of researchers, 38% (46) practitioners, 70% (7) of educators, with 50% of professional bodies (all professional bodies) and 60% (3) of professional bodies (all educators) also finding it

important. Both practitioners (38%, 46) and researchers (75%, 6) had some 'don't know' responses, with the remaining responses in the 'no' not important category.

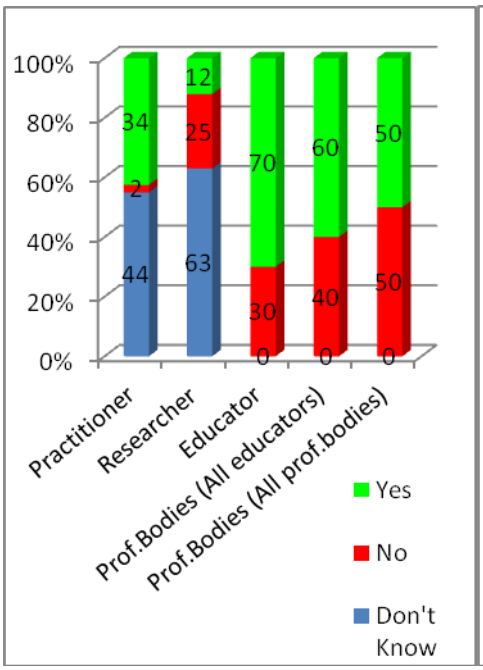

Figure 5.12: Importance of specialist training meeting H.NOS

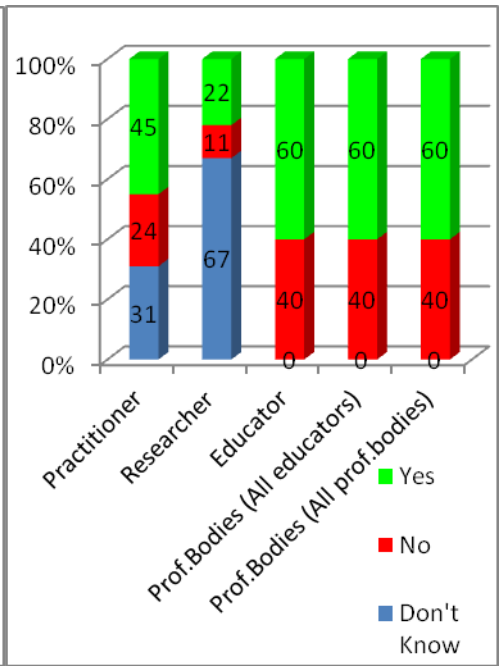

Figure 5.13:- Importance of CPD training meeting H.NOS

For specialist training (Figure 5.12), 12% (1) researcher considered it important for the training to meet H.NOS, rising to 34% (38) for practitioners and 70% for educators. For professional bodies (commenting on how important it was for all professional bodies) 50% (3) considered it important and 60% for professional bodies (commenting on how important it was for all educators). For practitioners 44% (49) and researchers 63% (5) did not know, with the remainder not considering it important.

For the CPD training, 22% (2) of researchers, 45% (60) of practitioners and 60% (6) of educators and professional bodies, both all professional bodies (4) and all educators (3) considered it important for the training to meet H.NOS (Figure 5.13).

A series of analyses (chi-square tests) were conducted to assess whether awareness or not of the H.NOS would have any influence on responses for the importance of training meeting H.NOS.

Awareness or not of the H.NOS and views on the importance of initial training meeting the H.NOS was analysed. Some 31% (*f*=22) of those not aware of the H.NOS (n=71) consider it important for initial level training to meet H.NOS, with some 23% (*f*=16) indicating it is not important and 46% (*f*=33) indicating it was not applicable. This compared with 64% (*f*=56) of those who were aware of the H.NOS (n=87) indicating it is important for initial training to meet H.NOS and 23% (20) indicating it is not important, with 13% (11) responding that it was not applicable.

A chi-square analysis of the frequencies between aware/not aware and the importance, or not, of initial training meeting H.NOS shows a significant difference, χ^2 (2, *N*=158) = 24.90, *p*<.001. The effect size was medium with *phi* = .397 (Figure 5.14).

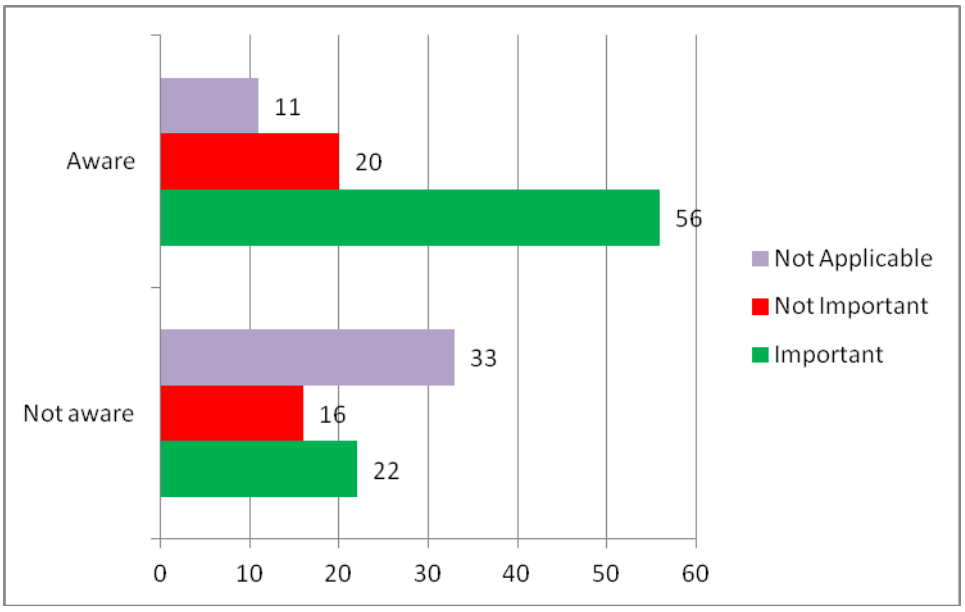

Figure 5.14: Awareness of H.NOS and the importance of initial training meeting H.NOS frequencies of response

Awareness or not of the H.NOS and views on the importance of practitioner training meeting the H.NOS was analysed. Here, 30% (*f*=20) of those not aware of the H.NOS (n=67) consider it important for practitioner level training to meet H.NOS, with a further 21% (*f*=14) indicating it is not important and 49% (*f*=33) indicating it was not applicable. This compared with 74% (*f*=65) of those who were aware of the H.NOS (n=88) indicating it is important for practitioner training to meet H.NOS and 16% (*f*=14) indicating it is not important, with 10% (*f*=9) responding that it was not applicable.

A chi-square analysis of the frequencies between aware/not aware and the importance, or not, of practitioner training meeting H.NOS shows a significant difference, χ^2 (2, *N*=155) =35.34, *p*<.001. The effect size was medium with *phi* = .478 (Figure 5.15).

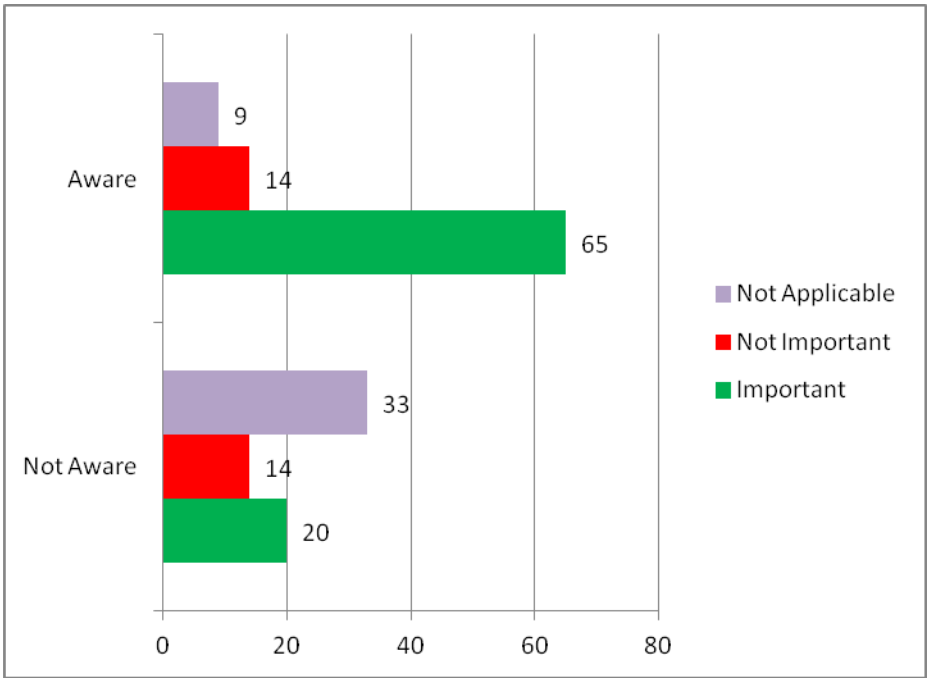

Figure 5.15: Awareness of H.NOS and the importance of practitioner training meeting H.NOS frequencies of response

Awareness or not of the H.NOS and views on the importance of advanced training meeting the H.NOS was analysed. Some 16% (*f*=9) of those not aware of the H.NOS (n=58) consider it important for advanced level training to meet H.NOS, with some 24% (*f*=14) indicating it is not important and 60% (*f*=35) indicating it was not applicable. This compared with 58% (*f*=37) of those who were aware of the H.NOS (n=64) indicating it is important for advanced training to meet H.NOS and 25% (*f*=16) indicating it is not important, with 17% (*f*=11) responding that it was not applicable.

A chi-square analysis of the frequencies between aware/not aware and the importance, or not, of advanced training meeting H.NOS showed a significant difference, χ^2 (2, *N*=122) = 29.48, *p*<.001. The effect size was medium with *phi* = .492 (Figure 5.16).

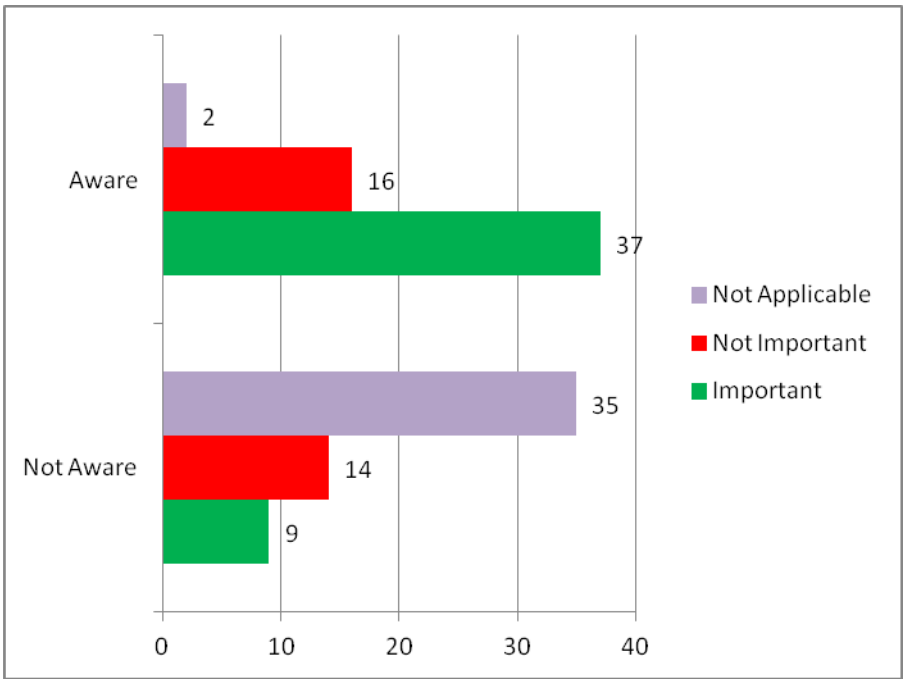

Figure 5.16: Awareness of H.NOS and the importance of advanced training meeting H.NOS frequency of response

Awareness or not of the H.NOS and views on the importance of specialist training meeting the H.NOS was analysed. Of the respondents, 16% (*f*=9) of those not aware of the H.NOS (n=55) consider it important for specialist level training to meet H.NOS, with a further 20% (*f*=11) indicating it is not important and 64% (*f*=35) indicating it was not applicable. This compared with 52% (*f*=29) of those who were aware of the H.NOS (n=56) indicating it is important for specialist training to meet H.NOS and 23% (*f*=13) indicating it is not important, with 25% (*f*=14) responding that it was not applicable.

A chi-square analysis of the frequencies between aware/not aware and the importance, or not, of specialist training meeting H.NOS showed a significant difference χ^2 (2, N=111) = 19.69, p<.001. The effect size was medium with *phi* = .421 (Figure 5.17).

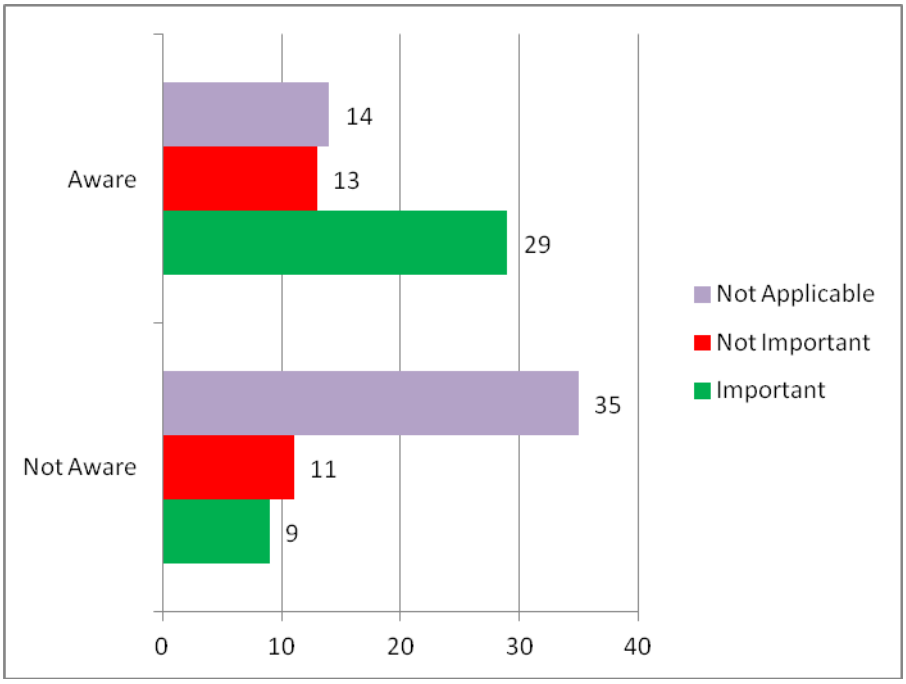

Figure 5.17: Awareness of H.NOS and the importance of specialist training meeting H.NOS frequency of response

Awareness or not of the H.NOS and views on the importance of CPD training meeting the H.NOS was analysed. Of the respondents, 23% (*f*=14) of those not aware of the H.NOS (n=61) consider it important for CPD training to meet H.NOS, with some 21% (*f*=13) indicating it is not important and 56% (*f*=34) indicating it was not applicable. This compared with 63% (*f*=46) of those who were aware of the H.NOS (n=73) indicating it is important for CPD training to meet H.NOS and 26% (*f*=19) indicating it is not important, with 11% (*f*=8) responding that it was not applicable.

A chi-square analysis of the frequencies between aware/not aware and the importance, or not, of CPD training meeting H.NOS showed a significant difference, $\chi^2(2, N=134) = 33.48$, $p<.001$. The effect size was large with *phi* = .500 (Figure 5.18).

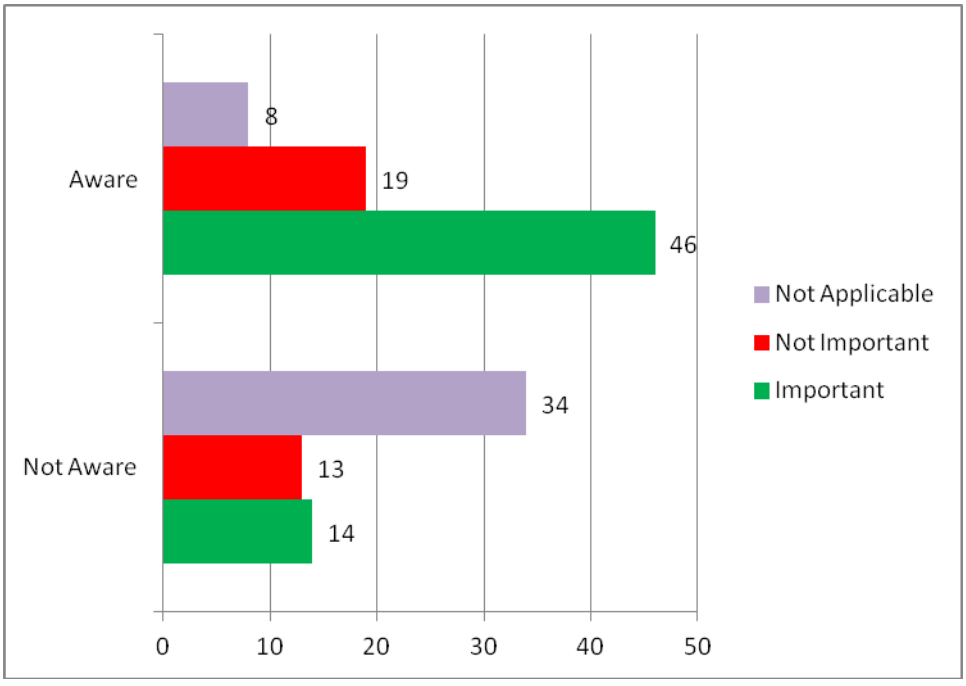

Figure 5.18: Awareness of H.NOS and the importance of CPD training meeting H.NOS frequencies of response.

Comments made in the questionnaire by practitioners included that H.NOS was not in existence when they trained (9), they were unaware of H.NOS (24) and do not consider it relevant (7). However 14 stressed it was important, 5 felt it necessary in order to feel confident or competent, or for professional standing (23), patient protection (9) or recognition / validation (6). Two researchers also indicated they trained prior to H.NOS and one considered it was good to have standards. This was echoed by educators, finding the H.NOS necessary for standards / quality (6) or the public (1). For professional bodies, they welcomed standards (1) although considered them not relevant to advanced training (1).

5.2.3.1 Summary of importance of training meeting H.NOS

Responses varied according to respondent group and training level. Although dependant on the type of training, one third to a half of practitioners considered it important for training to meet H.NOS, whereas researchers generally did not know. Educators were more strongly focused on H.NOS being important, as were professional bodies. A series of chi-square tests found those who were aware of the H.NOS found it more important for training to meet H.NOS that those not aware. Some questionnaire comments indicated a lack of awareness of H.NOS and a few that they did not consider H.NOS relevant, although many others focused on the positive influences on professionalism that result from the influence of H.NOS on training. Overall, those practitioners who were aware of the H.NOS considered it more important for training to meet H.NOS that those unaware of H.NOS. Furthermore, researchers generally did not know if it was important. Both educators and professional bodies were more strongly focused on the importance of training meeting the standards of H.NOS. Additional comments by questionnaire respondents focused on the perceived positive influence on professionalism resulting from training meeting H.NOS.

5.2.4 Use of H.NOS as criteria for standards and training

5.2.4.1 Present use of H.NOS as criteria for standards and training

Educator and professional body responses indicated that use of the H.NOS as criteria for standards and training varied. For professional bodies, high percentages were observed in initial, practitioner and advanced training, with low percentages in specialist and moderate percentages for CPD. For educators, the highest percentages were in

practitioner, specialist and CPD training, with moderate percentages noted for initial and advanced level training (Figure 5.19).

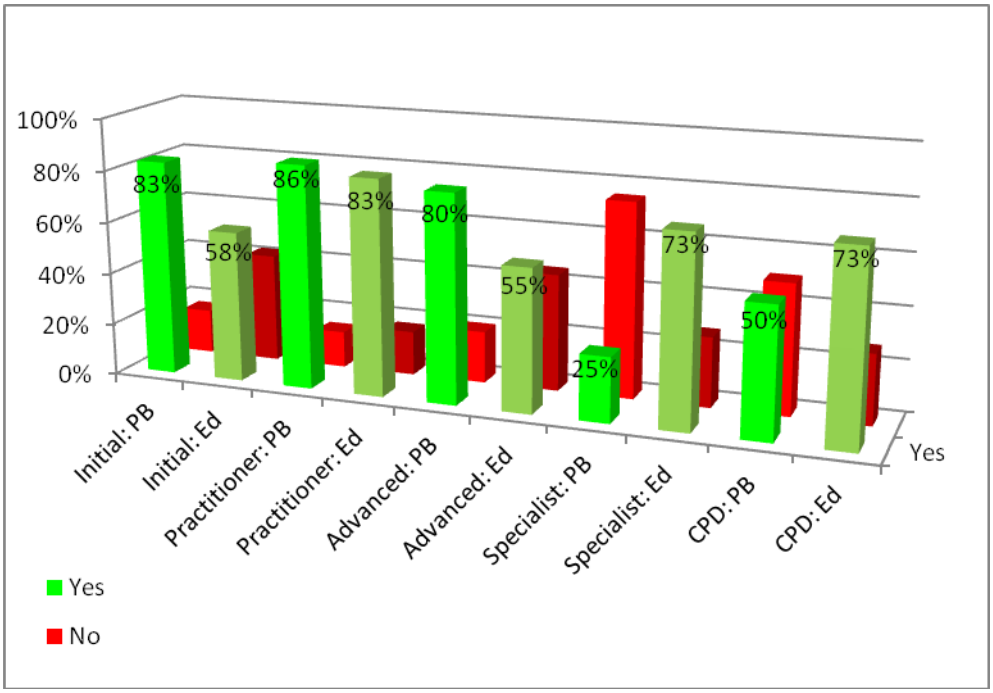

Figure 5.19: Professional body and educators' use of H.NOS as criteria for standards and training

Many of the professional bodies (n=7) presently use the H.NOS as criteria for standards and training, although this varies according to the training level. Not all professional bodies selected an option for each of the training level. At initial training level, 83% (5) presently use the H.NOS, similarly 86% (6) for practitioner level and 80% (4) for advanced level training. This drops vastly to 25% (1) for specialist training and moves to midway (50%, 2) for CPD training.

For educators (n=12), around half (58%, 7) use the H.NOS for initial training, notably less than professional bodies, although educators are similar (83%, 10) for practitioner training. However, for advanced training, again around half (55%, 6) of educators used the H.NOS, observably less than professional bodies. In contrast, for specialist training, 73% (8) of educators use the H.NOS, three times the percentage of professional bodies.

Lastly, for CPD training, 73% (8) educators use H.NOS, in contrast to just half of professional bodies.

Educators' comments (5) in the questionnaire ranged from the need for training standards (1), the need to teach students about H.NOS (1) and those standards are followed (3). For professional bodies there were few comments, with one indicating that the H.NOS were not relevant to their type of training.

5.2.4.2 Action taken by professional bodies and educators in response to H.NOS

Almost half of the professional body (n=7) respondents (43%, 3) revised their professional standards to meet the H.NOS, and almost all professional bodies amended guidelines to educators (86%, 6). Only a quarter (27%, 3) of educators (n=11) indicated being aware of changes their professional bodies have made in response to the H.NOS, although 67% (8) made changes in response to H.NOS and 55% (6) considered those amended added benefits (Figure 5.20).

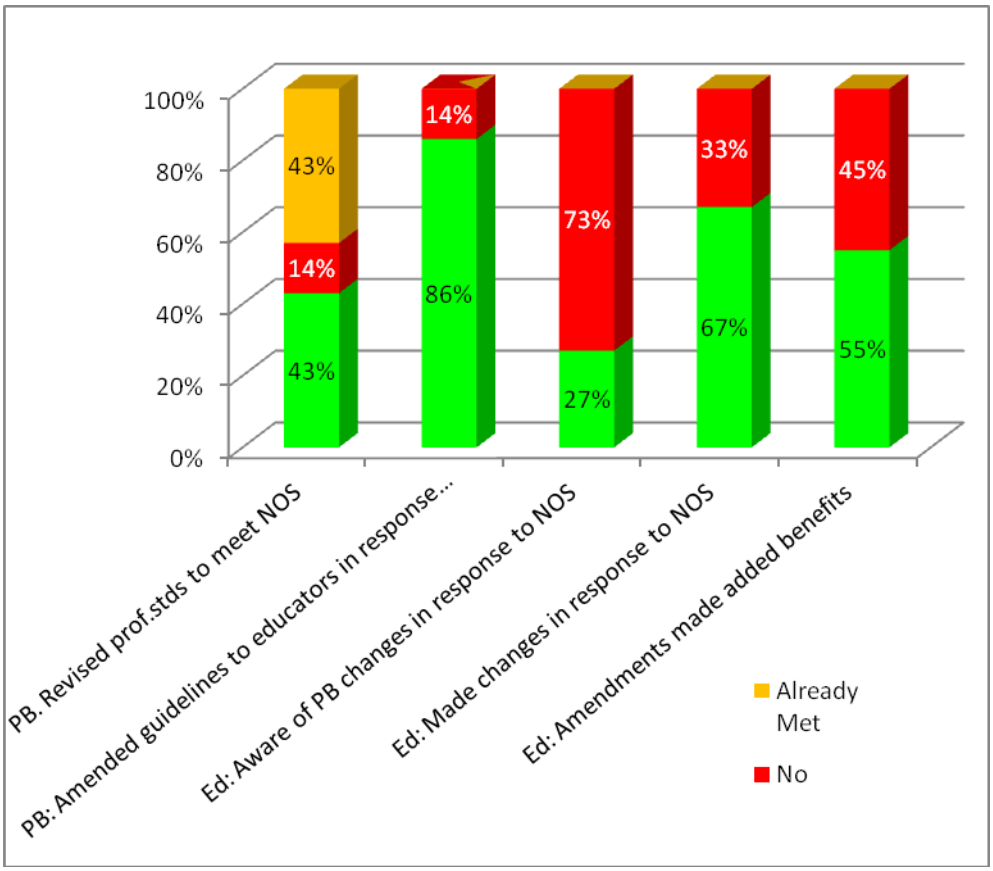

Figure 5.20: Professional Body and Educator training actions in response to H.NOS

Few comments were made by respondents in relation to training actions, for educators, these included *"no interest"* (3), that their standards are *"already similar"* (1), or they made training which *"broadened the scope of training"* (1).

5.2.4.3 Summary of use of H.NOS as criteria for standards and training

Generally, in the questionnaire responses, both educators and professional bodies use H.NOS as criteria for standards and training for all levels, with just a few professional bodies using it for specialist training. Furthermore, although only half of professional bodies revised their professional standards to meet H.NOS, almost all informed educators of their amended guidelines. However, a quarter of respondents indicated being aware of their professional body changes in response to H.NOS. For educators, around two-thirds made changes in response to H.NOS and over half consider this added benefit.

Comments in the questionnaires were generally positively focused around the need for standards and compliance with the standards, with comments indicating they had no need to amend training as their own was already similar, and with others indicating the changes broadened the scope of training.

5.3 Influence of the H.NOS on professionalism – Research Question No. 2

5.3.1 H.NOS influence upon perception of professionalism and extent of professionalism

5.3.2 H.NOS Influence upon competence standards in the UK

5.3.3 H.NOS reflection of professional competence standards in the UK

5.3.4 Professional body changes to training criteria in response to H.NOS and influence of H.NOS on professional bodies

5.3.5 Awareness of changes to professional standards and action Taken

5.3.6 H.NOS relevant to hypnosis / hypnotherapy research

5.3.7 Group perceptions for T.A.P. level the H.NOS best reflects

5.3.8 Professional body and educator T.A.P. level for own practitioner / general practitioner training

5.3.9 Practitioner training and T.A.P. levels

5.3.10 Researcher training and T.A.P. levels

As will be observed in the reporting of data, there appears to be a moderately positive perception of the influence of the H.NOS on professionalism, with revisions to professional standards made and their influence recognised. The T.A.P. model (Appendix A6), which has levels relating to thought, action, and professionalism, did generate varied responses, although generally it would appear that levels 3 (intermediate) and level 4 (practitioner) most commonly reflect views of practice.

It can be noted that only a third of researchers considered H.NOS relevant. In the questionnaires, a third of respondents indicated positive influences on perception and extent of professionalism. Such divided views carry through to perceptions of influence upon professional competence standards with researchers less positive than practitioners, with the focus between positive and no influence. Practitioners and researchers views indicate they consider the H.NOS reflect between general and the minimum professional competence standards. However, whilst educators concur and find this reflects their own standards, professional bodies regard the H.NOS to be at a

lower standard to their own professional competence standards. Professional bodies did make changes to their training criteria in response to H.NOS and the extent of influence on the H.NOS on professional bodies is generally mildly positive. Furthermore, over half of practitioners and researchers were aware of changes professional bodies made to their professional standards and of those undertaking further training most found it beneficial.

When considering the T.A.P. model, responses generally considered the H.NOS sat between level 3 and 4 with professional bodies and educators also focusing at these levels for their own training standard, although some consider that qualifications and experience may have an influence upon resultant levels. Practitioners generally self-rated their T.A.P. level at slightly higher than at the time of their qualification and at the level they consider appropriate for qualified practitioners. This could support the influence of experience and possibly CPD. Researchers responses differed from the other three groups, and generally focused at level 6.

5.3.1 H.NOS Influence upon perception and extent of professionalism

In all four respondent groups the highest percentage of responses were in the 'none' category (59%, 89) for H.NOS influence upon the perception of professionalism (Figure 5.21). However, although practitioner and researcher responses were closely divided between 'none' and 'positive' the educators and professional body responses were more greatly focused in the 'none' category. The distribution of responses differs for the H.NOS influence upon the extent of professionalism (Figure 5.22). Although the 'none' category again had the highest percentages of respondents (64%, 90), the divisions were only closely matched for the researcher group.

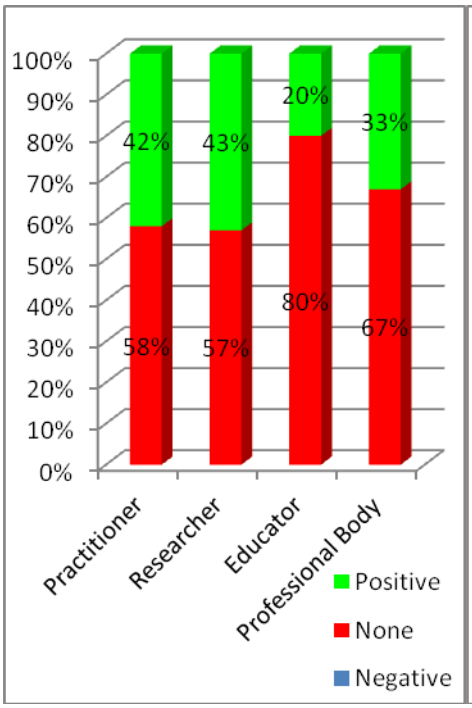

Figure 5.21: H.NOS influence upon perception of professionalism

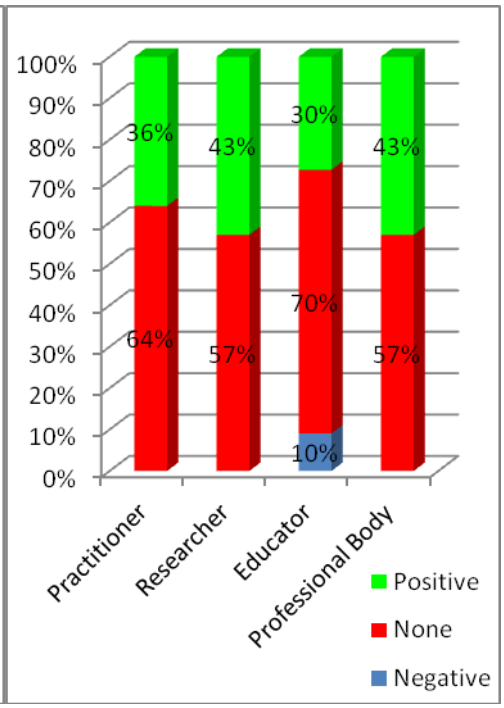

Figure 5.22: H.NOS influence upon extent of professionalism

The practitioners (n=127) view of the H.NOS influence upon the perception of professionalism considered there was mainly no influence (58%, 73) as compared to a positive influence for 42% (54), whereas for the extent of professionalism rather more (64%, 75) considered there was none, as compared to 36% (42) considering there was a positive influence. The researchers (n=7) were divided more closely, with 57% (4) considering 'none' for both perception and extent, and 43% (3) considering a positive influence. Of the educators (n=10) although 80% (8) considered 'none' for influence on perception of professionalism and 20% (2) viewed there was a positive influence, for extent of professionalism this changed to 70% (7) for 'none' and 20%(2) for positive, with one respondent (10%) considering a negative influence. The professional body respondents (n=7) were more closely divided, with 67% (4) considering none and 33% (2) considering positive for perception of professionalism and 57% (4) considering none for extent, together with 43% considering other.

For practitioner responses, an analysis was conducted to assess whether awareness or not of the H.NOS would have any influence on responses. Awareness or not of the H.NOS and the influence of H.NOS on the perception of professionalism was analysed with a chi-square test. Some 25% (*f*=12) of those not aware of the H.NOS (n=48) found the H.NOS were a positive influence on the perception of professionalism, with 75% (*f*=36) finding it was no influence. This compared with 53% (*f*=42) of those who were aware of the H.NOS (n=79) finding the H.NOS a positive influence and 47% (*f*=37) finding it to be no influence.

A chi-square analysis of the frequencies between aware/not aware and the perception of professionalism showed a significant difference, χ^2 (1, *N*=127) = 9.69, *p*=.002. The effect size was small with *phi* = .276 (Figure 5.23).

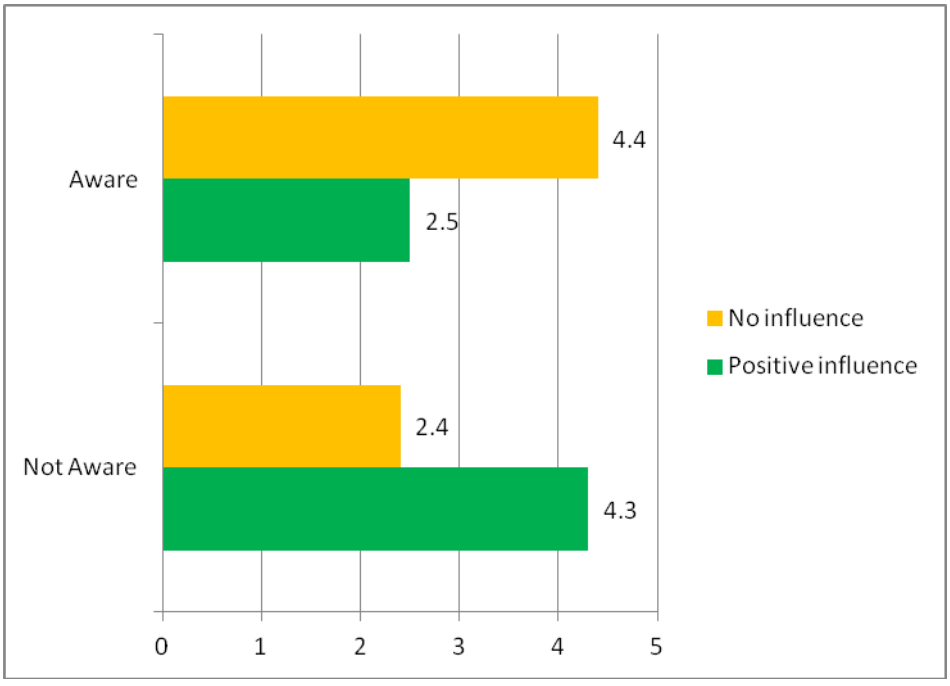

Figure 5.23: Awareness of H.NOS and influence of H.NOS on the perception of professionalism frequencies of response

Also for practitioner responses, awareness or not of the H.NOS and the influence of H.NOS on the extent of professionalism was analysed with a chi-square test. Some 20% (*f*=9) of those not aware of the H.NOS (n=46) found the H.NOS were a positive influence on the extent of professionalism, with 80% (*f*=37) finding it was no influence. This compared with 46% (*f*=33) of those who were aware of the H.NOS (n=71) finding the H.NOS a positive influence and 54% (*f*=38) finding it to be no influence.

A chi-square analysis of the frequencies between aware/not aware and the extent of professionalism showed a significant difference, $\chi^2(1, N=117) = 8.79$, $p=.003$. The effect size was small with *phi* =.274 (Figure 5.24)**.**

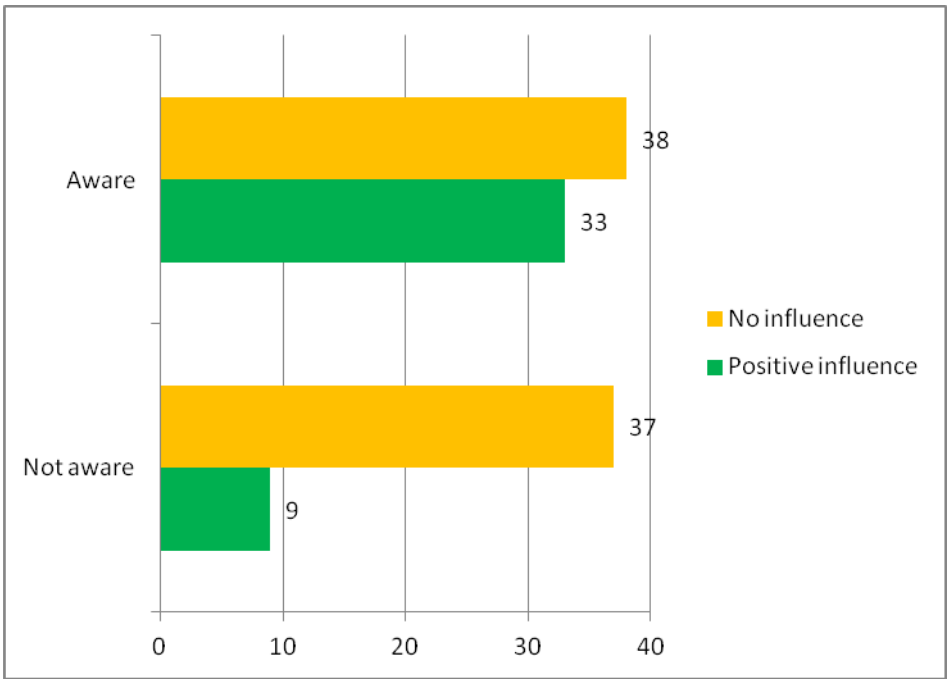

Figure 5.24: Awareness of H.NOS and influence of H.NOS on the extent of professionalism frequencies of response

Practitioner comments (73) in the questionnaire mainly supported their selections from the offered answers to the questions in the questionnaire, although there were more negative (51) comments to positive (21) comments. Practitioners did consider the H.NOS would be a positive influence if all adopted them (1) considering "*H.NOS are necessary"* (3) and the standards were a start towards and signs of increased professionalism (12). They further considered that the H.NOS could develop

practitioners (2) and gain public recognition (2) by setting a standard (1). However, practitioners also commented that they did not know the standards (24), considered it is too early to tell (1) and that "*the standards don't go far enough"* (1) nor are not widely enough adopted (5) nor widely known (12), with "*too much variation in standards*" (1). Furthermore, some considered there was fragmented representation with too many professional bodies (1), that the H.NOS had no influence (4) or minimal influence (1) and were poor perceived by the medical profession (1).

Researchers comments in the questionnaire (2) were few and ranged from 'do not know' (1) to 'a positive influence was desired'. Educators also le few comments (4), indicating students seek recognised qualifications (1) and that they are unsure of influence of H.NOS (2)and their "*use needs formalising*" (1). The professional bodies group just indicated that one respondent felt they were not sufficiently informed.

5.3.1.1. Summary of H.NOS influence upon perception of professionalism and extent of professionalism

Questionnaire responses by practitioners and researchers, on the topic of perception of professionalism, were divided between no influence and positive, educators were mainly of the view of no influence, professional bodies two-thirds towards a view of no influence. The proportions changed slightly for extent of professionalism, with researchers and professional bodies closely divided, and practitioners and educators with slightly greater proportions in no influence. Generally, all groups for both questions had majority responses in the 'no influence' category. A chi-square test for practitioners' responses indicated more of the respondents who were aware of the H.NOS considered it to have had no influence upon the perception of professionalism compared to those who were not aware of the H.NOS. Another test was performed for the extent of professionalism. Here the respondents aware of the H.NOS had notably greater responses in the 'positive influence' than those not aware, although 'no influence' still had the majority of responses. Responses in the questionnaires generally supported the question response selections, with only one third of comments positive. Overall, around one third of respondents found there to be a positive influence on perception and extent of professionalism.

5.3.2 H.NOS influence upon professional competence standards in the UK

When considering the influence of the H.NOS upon professional competence standards in the UK (Figure 5.25), all four respondent groups (n=154) had the greatest distribution of responses in the 'no influence' category (51%, 78), although the 'minor positive influence' (37%, 57) was also notable.

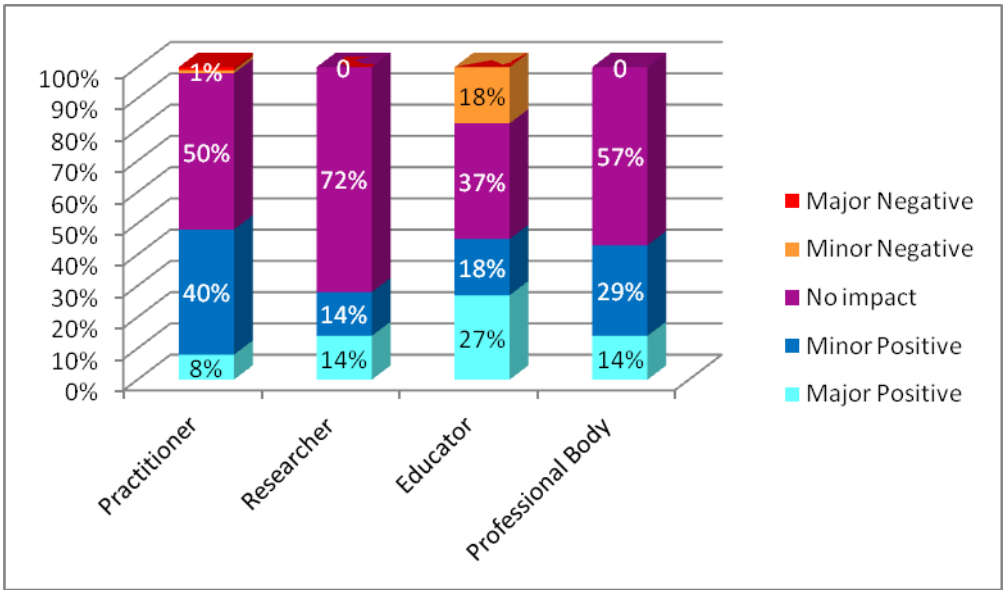

Figure 5.25: H.NOS influence upon professional competence standards in the UK

The practitioner group (n=129) were closely divided between no influence (50%, 65) and minor positive influence (40%, 52) with just 8% (10) considering there to be a major positive influence and 1% (1) in each of the minor and major negative influence categories. For researchers, they were more focused around the no influence (72%, 5) to minor and major positive influence (14%, 1) each. Of the four groups, educators were the least focused in the no influence category (37%, 4) with 18% (2) considering there to have been a minor positive influence and 27% (3) a major positive influence. However, 18% (2) indicated a negative positive belief. None of the professional bodies (n=7) considered there to be any negatives. Also 57% (4) considered there to be no influence, a further 29% (2) regarded there to be a minor positive influence and 14% (1) a major positive influence.

For practitioner responses, an analysis was conducted with a chi-square test to assess whether awareness or not of the H.NOS would have any influence on responses. Professional competence standards responses were poorly distributed for a chi-square test (2 cells had expected values less than 5) and thus were re-coded to 'positive' and 'not positive'. Awareness or not of the H.NOS and views on the influence of the H.NOS on professional competence standards (PCS) was analysed. Some 20% (*f*=10) of those not aware of the H.NOS (n=51) considered the H.NOS had a positive influence on the PCS, with some 80% (*f*=41) indicating they did not consider the H.NOS had had a positive influence on PCS. This compared with 67% (*f*=52) of those who were aware of the H.NOS (n=87) indicated a positive influence on PCS and 33% (*f*=26) indicating they did not consider the H.NOS had had a positive influence.

A chi-square analysis of the frequencies between aware/not aware and the influence on PCS showed a significant difference, χ^2 (1, *N*=129) = 27.36, *p*<.001. The effect size was medium with *phi* = .370 (Figure 5.26).

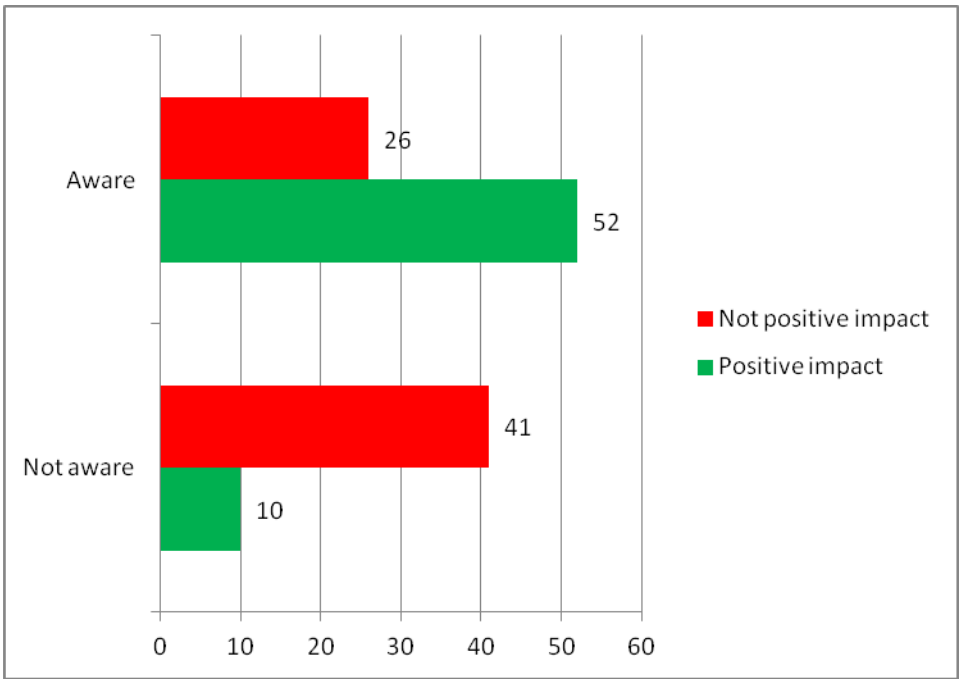

Figure 5.26: Awareness of H.NOS and influence of H.NOS on professional competence standards in the UK frequencies of response

Of the questionnaire textual comment responses, although these indicated 'no influence' to 'mildly positive' in their questionnaire answer selections, of the 84 practitioners who also commented, 73 had negative comments. These ranged from not being aware of any influence (44) to a view that the H.NOS are "*not adopted by all*" (14), they are not widely enough known (5), "*don't go far enough*" (3), are too hard to gauge (2) and that it is too early to assess (1). One practitioner also suggested they are "*not highly enough regarded by the medical profession"*. In contrast are the positive views that the H.NOS standardises training (1) "*reflects the basics*" (1), will start to have an influence (6), offer helpful standards for the public (2) and, "*when fully adopted, will aid professionalism"* (1). Of the researchers (4) who commented, 3 do not know and 1 considered there to be no influence. For educators (3) they consider there to be a lack of awareness or uptake in schools (2), although *"not all practitioners are competent"* (1) and "*anything after nothing is a big influence*" (1). The professional body comment (1) was that they were insufficiently informed to comment.

5.3.2.1 Summary of H.NOS Influence upon competence standards in the UK

Of the questionnaires responses, for around half of practitioners, educators and professional bodies and one-third of researchers, the H.NOS had a positive influence, with the remaining responses focused around no influence. A chi-square test was conducted of those practitioners who were or were not aware of the H.NOS and their view of whether the H.NOS was a positive or not positive influence on professional competence standards. It was observed that of those aware, notably more respondents considered there to be a positive influence, whereas for those not aware, responses were in the opposite direction with more considering them as having no influence. Almost 90% of comments made could be considered negative, even where a positive response was indicated in the questionnaire with views often indicating a lack of awareness and that they do not go far enough. Overall, it would appear that there is a division between positive and no influence, although with less influence for researchers. Practitioners who were aware of the H.NOS viewed it as having more influence than those not aware. Comments were made regarding a lack of awareness and scope, with practitioners generally more positive than professional bodies and researchers least aware of any positive influence.

5.3.3 H.NOS reflection of professional competence standards in the UK

In addition to exploring the influence the H.NOS may have had upon professional competence standards in the UK, this research also sought respondents views how the H.NOS reflect the professional competence standards in the UK generally, and, for the educators and professional bodies, how the H.NOS reflect to their own organisations' professional competence standards (Figures 5.27 and 5.28).

All four respondent groups had the greatest distribution of responses in the category that indicated that the H.NOS reflect the minimum professional competence standards in the UK. However, practitioners and educators had a less high percentage of respondents in that category than researcher and professional body. Furthermore, the educators regarded the H.NOS as being of a similar standard to their own standards, whilst the professional bodies considered the H.NOS represented a lower standard than their own organisations' standards.

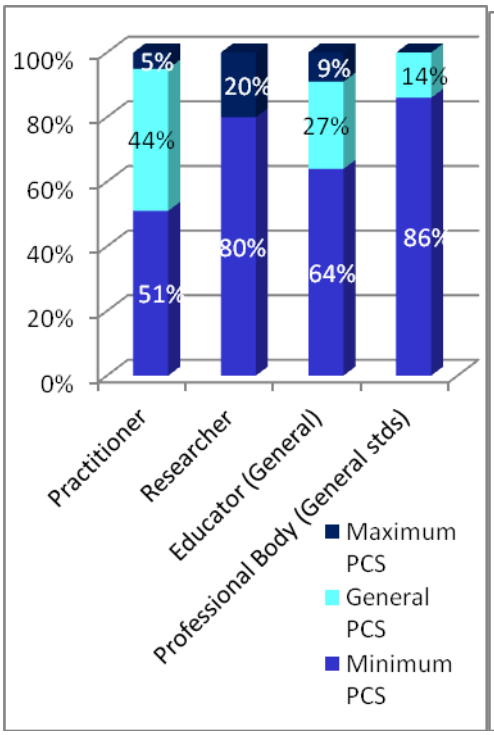

Figure 5.27: Group PCS perceptions

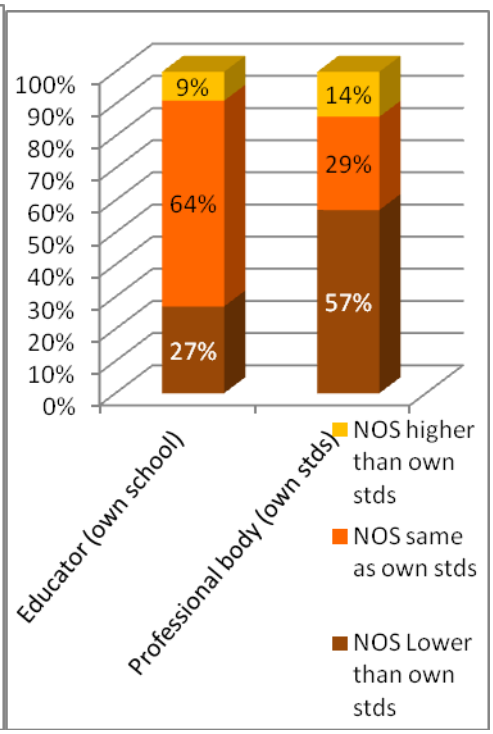

Figure 5.28: Comparison of PCS

The practitioners (n=127) indicated the H.NOS reflected the minimum professional competence standards (PCS) for 51% (65) with 44% (56) considering the reflected the

general PCS and just 5% (6) regarding them as reflecting the maximum professional competence standards. This contrasted with the researchers (n=5) of whom 80% (4) considered they reflected the minimum PCS and 20% (1) regarding them as reflecting the maximum PCS. Educators (n=11) were more divided in their opinions, with 64% (7) considering them as meeting the minimum PCS, 27% (3) the general PCS and 9% (1) the maximum PCS. 86% (6) of professional bodies (n=7) regarded the H.NOS as reflecting the minimum PCS, compared to 14% (1) regarding them as meeting the general PCS.

Educators (n=11) and professional bodies (n=7) differed on how the H.NOS compared to the standards of their own organisation as 64% (7) of educators considered the H.NOS were a similar standard to their own, with 27% (3) considering them to be lower and 9% (1) considering the H.NOS to be of a lower standard. In contrast, 57% (4) of the professional body respondents considered the H.NOS to reflect a lower standard than their own organisation, with 29% (2) considering them to be similar and 14% (1) considering them to reflect a higher standard than their own organisation.

Practitioner respondents comments were varied, including "*no real knowledge of NOS / don't know*" (40) and that "*NOS are needed for a unified voice*" (1) and NOS needed for professionalism (1) and appear thorough / balanced (3). Furthermore, that NOS lack depth (4) lack comprehensive adherence (1) and little has changed (2). All three researchers' comments indicated 'do not know'. However, Educators were divided, with two indicating they reflect professional standards and one that they do not. Furthermore, for their own organisation, one considered them not relevant and one indicated they go beyond the NOS. Professional body views are that they are the same or similar in terms of standards (2) and that the H.NOS reflected professional standards.

5.3.3.1 Summary of H.NOS reflection of Professional Competence Standards (PCS) in the UK

In the questionnaires responses, around half of practitioners, and 90% of researchers considered the H.NOS represented the minimum PCS in the UK. For almost half of practitioners the H.NOS reflected the general PCS. Thus it would appear for many educators their PCS reflect the H.NOS standard at 'minimum PCS' level, whereas for many professional bodies, they consider their own standards higher. Questionnaire

comments reflected respondents' questionnaire response selections, which, for practitioners, further highlighted a lack of awareness of H.NOS as having influenced upon their ability to answer from an informed perspective. Educators were divided in their views on whether the H.NOS reflect PCS and professional bodies indicate a view that H.NOS do reflect PCS. Overall, it can be observed that for practitioners the H.NOS reflect between minimum and general PCS, with researchers finding them more focused towards minimum. Whilst educators view them as the minimum PCS and indicate these reflect the same level as their own organisation, professional bodies consider their own standards as higher than the H.NOS that they regard as also reflecting the minimum PCS.

5.3.4 Professional body changes to training criteria in response to H.NOS and influence of H.NOS on professional bodies

When the professional bodies were asked if they had made changes to any of their training criteria to meet the requirements of the H.NOS, their responses varied according to the type of training. It would appear (Figure 5.29) that more professional bodies amended their practitioner, initial and CPD training, than they did for advanced or specialist training.

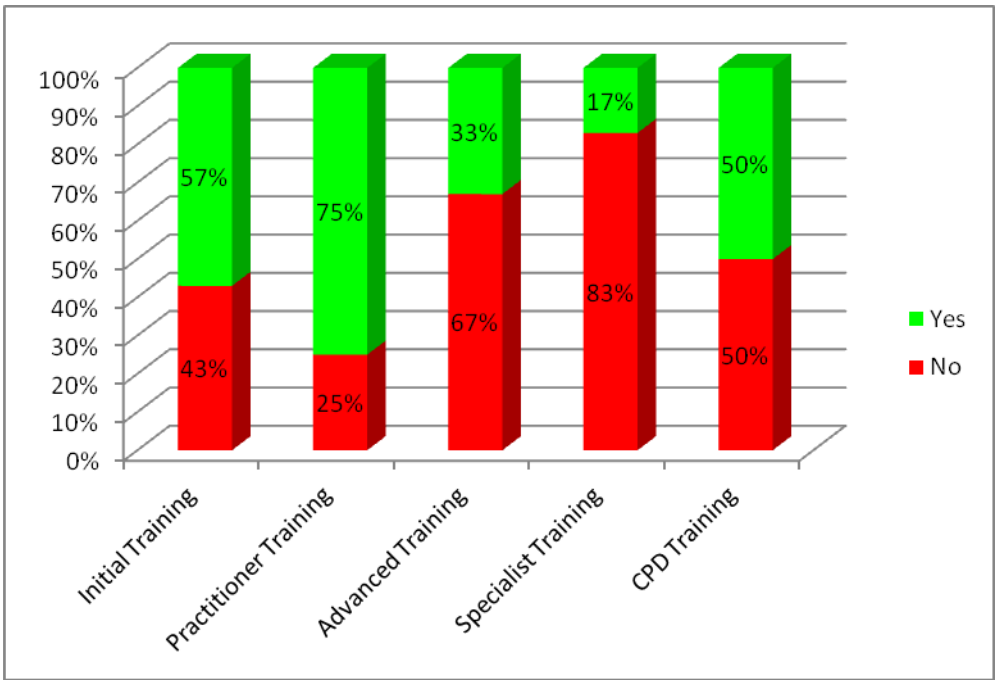

Figure 5.29: Professional body changes to training criteria in response to H.NOS

Professional body (n=8) changes to initial training were made by 57% (4), and practitioner training 75% (6) yet not as much to advanced training, (33%, 2) or specialist training (17%, 1). There was an equal division (50%, 3) between those who did and did not change CPD. Of the professional bodies who made comments (2) in the questionnaires, both indicated these changes were required by the CNHC.

5.3.4.1 Summary of Professional body changes to training criteria in response to H.NOS and influence of H.NOS on professional bodies

From questionnaire responses, for professional bodies, changes to training criteria were indicated for all levels of training, from initial training through to CPD training, with one third or less changing advanced and specialist training, rising to a half changing initial and CPD training and three-quarters changing practitioner training. Both comments in the questionnaires indicated these changes were required by the voluntary regulatory body, the CNHC. Overall, it can be concluded that professional bodies made changes to training criteria in response to the H.NOS with the greatest focus of change amongst initial and practitioner training and also to CPD training. Views on the extent on influence of the H.NOS on professional bodies are mildly positive.

5.3.5 Awareness of changes to professional standards as a result of H.NOS and action taken

Few practitioners or researchers were aware of changes made by their professional body in response to the H.NOS (Figure 5.30) and very few undertook further training as a result of these changes. However, of those practitioners who did undertake further training, some indicated it was beneficial.

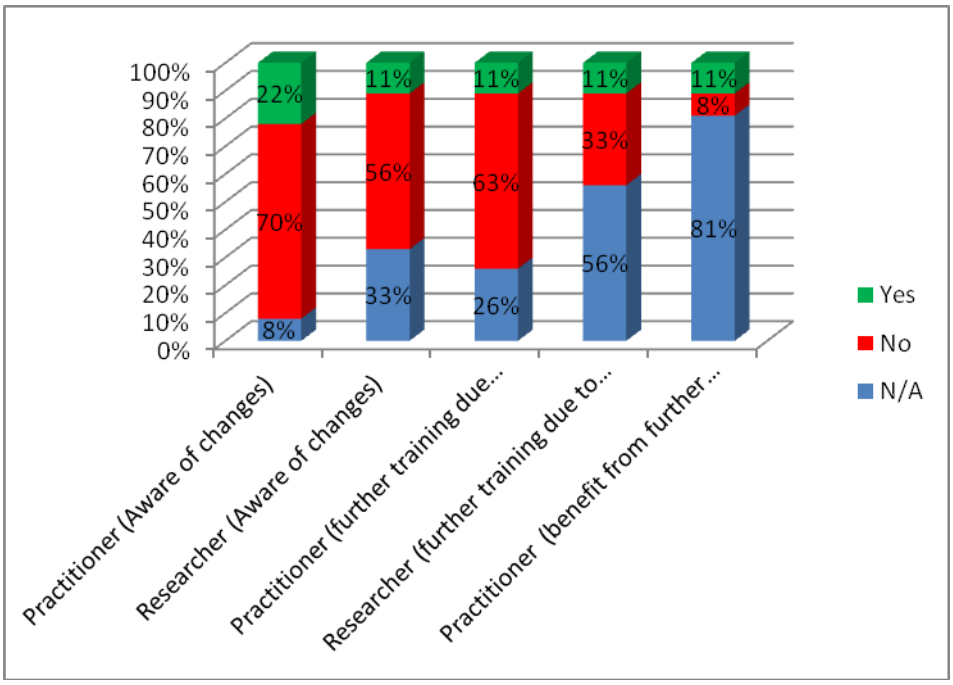

Figure 5.30: Awareness of changes to professional standards and action taken

Practitioners (n=163) were generally not aware (70%, 114) of changes that their professional body made to professional standards, with just 22% (36) being aware. Furthermore, when practitioners (n=163) asked if they undertook further training to meet revised standards, only 11% (18) did, with 63% (103) indicating they did not. However, of those practitioners (n=160) asked if they were aware of any benefits from the further training undertaken, 11% (17) did consider there were benefits, 8% (13) considered there were no benefits and 81% (130) indicated this was not applicable to themselves.

Researchers (n=9) were less aware of changes made by their professional body with only 11% (1) being aware, 56% (5) being unaware, with 33% (3) considering this is not applicable to them. Of those who were asked if they had undertaken further training to meet changes in standards by their professional body (n=9) one (11%) said they had, whereas 33% (3) said it hadn't and 56% (5) considered the question was not applicable to them.

5.3.5.1 Summary of awareness of changes to professional standards and action taken

Overall, in the questionnaire responses, over half of Practitioners (70%) were aware of changes by their professional body to professional standards, with over 60% undertaking further training and 80% then finding it beneficial. For researchers over half were aware of changes and one third undertook further training.

5.3.6 H.NOS relevant to hypnosis / hypnotherapy research

Of the researchers who completed the question about the H.NOS relevance to hypnosis / hypnotherapy research (n=9), two thirds (67%, 6) considered they were not relevant, whereas 33% (3) considered they were relevant (Figure 5.31). It is acknowledged that the sample size was small.

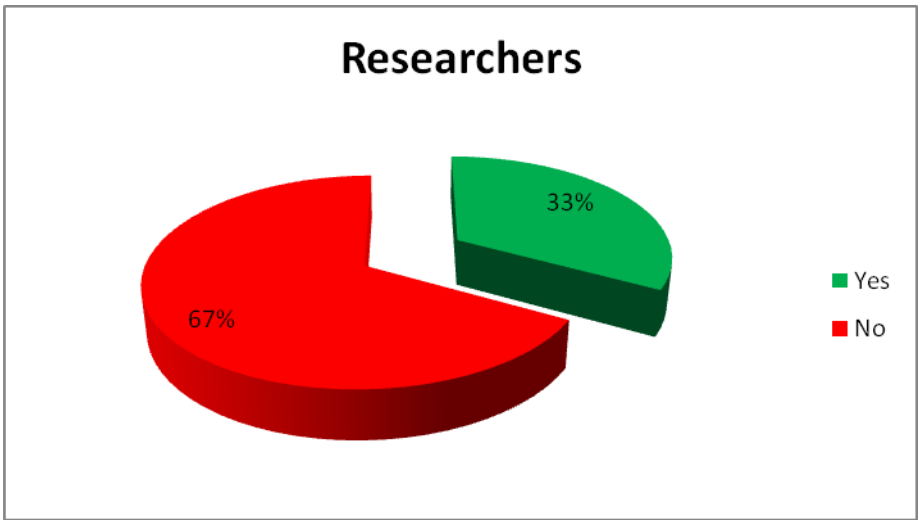

Figure 5.31: H.NOS relevant to hypnosis /hypnotherapy research

5.3.7 Group perceptions for T.A.P. level the H.NOS best reflects

The four respondent groups were divided in their opinions as to which level in the T.A.P. model the H.NOS best reflects, with the greatest number of respondents focusing around level 3 (intermediate) and 4 (practitioner) (Figure 5.32).

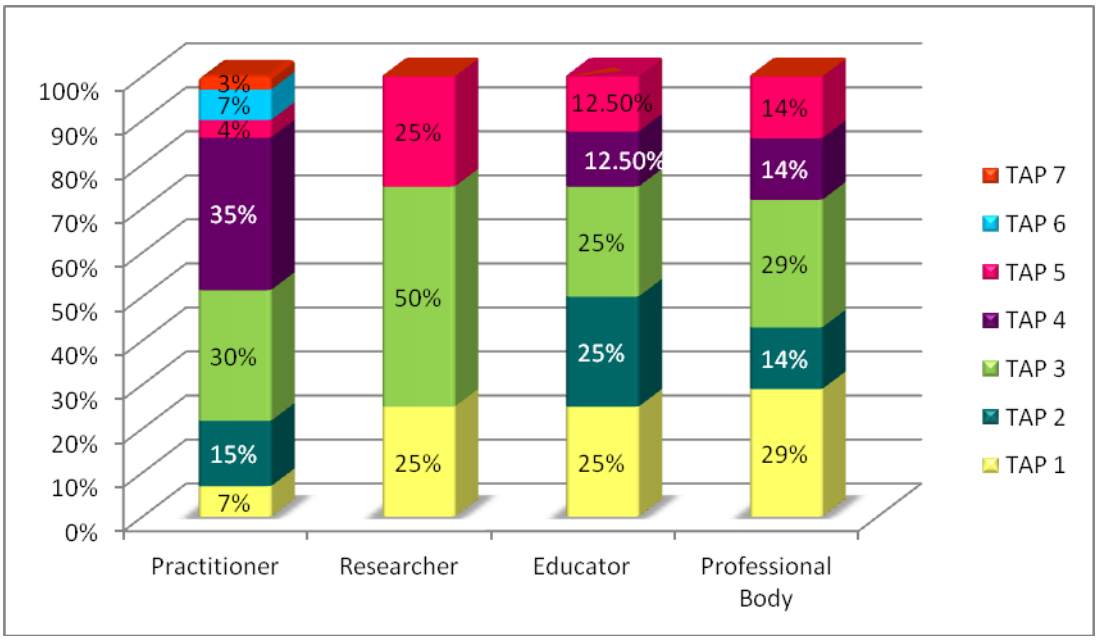

Figure 5.32: Group perceptions for T.A.P. level the H.NOS best reflects

The practitioners (n=125) responses were mainly focused on level 3 intermediate (30%, 35) and level 4 practitioner (35%, 40), with some also at level 2 novice (15%, 27) and the remainder spread to level 1 (7%, 8) and through level 5 (4%, 4) and level 6 (7%, 8) to level 7 (3%, 3). However, researchers (n=4) were more focused around three levels, with 25% (1) at level 1, 50% (2) at level 3 and 25% (1) at level 5. Educators (n=8) were spread between the first five levels with 25% (2) in levels 1, 2 and 3 and 12.5% (1) in each of levels 4 and 5. Professional bodies (n=7) were also spread amongst the first five levels with 29% (2) in levels 1 and 3, and 14% (1) in levels 2, 4 and 5.

For practitioner responses, an analysis was conducted to assess whether awareness or not of the H.NOS would have any influence on responses. A chi-square test was attempted, but could not validly be conducted due to low expected frequencies.

Comments from the questionnaires, from educators (5) were similar in that "*training should create a suitable level of independent competence*" (3) and that "*supervision can mitigate lack of competence*" (2). The single professional body comment indicated a view that the H.NOS "*reflect minimum standards*".

5.3.7.1 Summary of Group perceptions for T.A.P. level the H.NOS best reflects

Respondent groups were divided in their opinion of where the H.NOS best fits into the T.A.P. model. Around half of practitioners, educators and professional bodies and three-quarters of researchers considered it best fit into T.A.P. levels 1 to 3, with only one third of practitioners, and less than a fifth of educators and professional bodies considered it achieved level 4. Relatively few respondents considered it would be at level 5 or above, apart from a quarter of researchers who considered it fitted into level 5.

Questionnaire comments were limited and focused on competence, both independent and supervised. Overall, questionnaire responses indicated a stronger focus towards T.A.P. level 3 and a milder focus towards T.A.P. level 4.

5.3.8 Professional body and educator T.A.P. level for own practitioner training / general practitioner training

Professional bodies and educators were asked to indicate the T.A.P. level that best reflected their own practitioner training and best reflects general practitioner level training. Most educators and professional bodies questionnaire responses focused around levels 3 and 4 for their own levels and for general practitioner training (Figure 5.33).

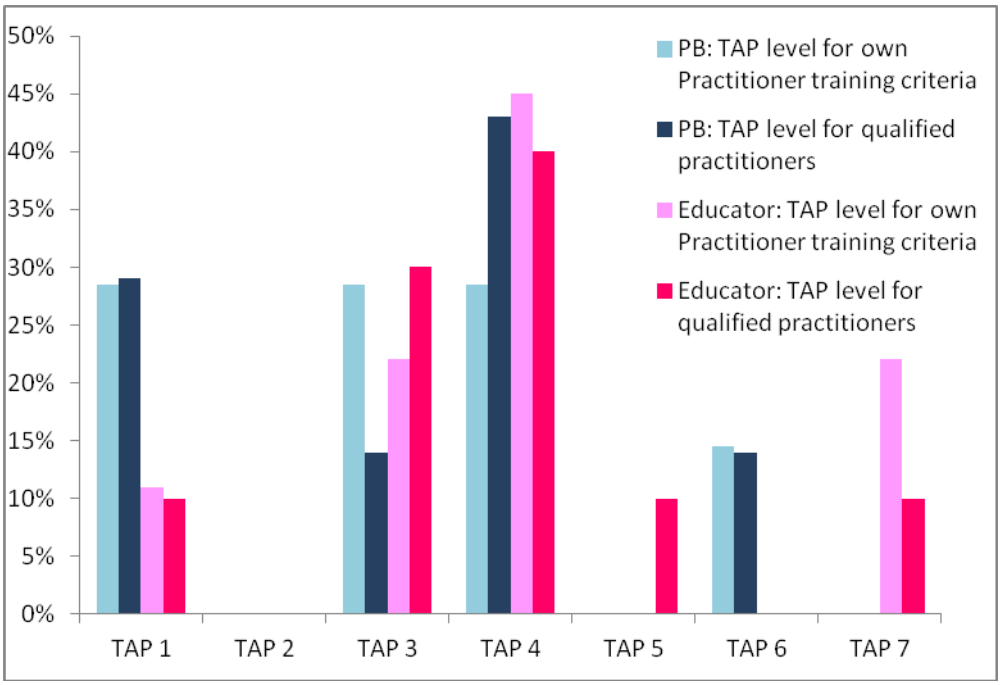

Figure 5.33: Professional Body and Educator T.A.P. level for own practitioner training and perceived level for general practitioner level training

Of the educators responses (n=9) 45% (4) considered level 4 and 22% (3) level 3 as the most relevant level for their practitioner training, with 11% (1) at level 1, and 22% (2) at level 7. Professional bodies (n=7) were more evenly dispersed with 28.5% (2) at levels 1, 3 and 4, with 14.5 % (1) at level 6.

Responses were also dispersed for the T.A.P. level educators (n=10) and professional bodies (n=7) consider practitioners should achieve at qualification, although focused at levels 3 and 4. For educators, level 3 (30%, 3) and level 4 (40%, 4) had the majority of responses, with 10% (1) in each of levels 1, 5 and 7. For professional bodies, 15% (1) at level 3 and 43% (3) at level 4 were the closest levels of responses, also with 29% (2) at level 1 and 14% (1) at level 6.

5.3.8.1 Summary of professional body and educator T.A.P. level for own practitioner / general practitioner training

The focus of questionnaire responses from professional bodies and educators for the T.A.P. level of their own practitioner training and their view on which T.A.P. level a qualified practitioner should fit were mainly focused around level 3 and 4, with some focus on T.A.P. level 1, with few responses in level 5 and above. Overall, responses are generally focused around level 3 and 4, with some views focused on level 1 and other views indicating the level is determined by qualifications and experience. This implies that generally, excluding a few extreme responses, that T.A.P. levels 3 and 4 most accurately reflect the training level of a practitioner.

5.3.9 Practitioner training and T.A.P. levels

Practitioners varied in their views as to where their level of training fitted into the T.A.P. model (levels 4 and 5) and how they presently rate themselves (levels 4 and 6). Responses for the first two questions were not closely mapped to the T.A.P. levels, although for the third, relating to T.A.P. levels for a qualified practitioner, this was closely around levels 2 and 3 (Figure 5.34).

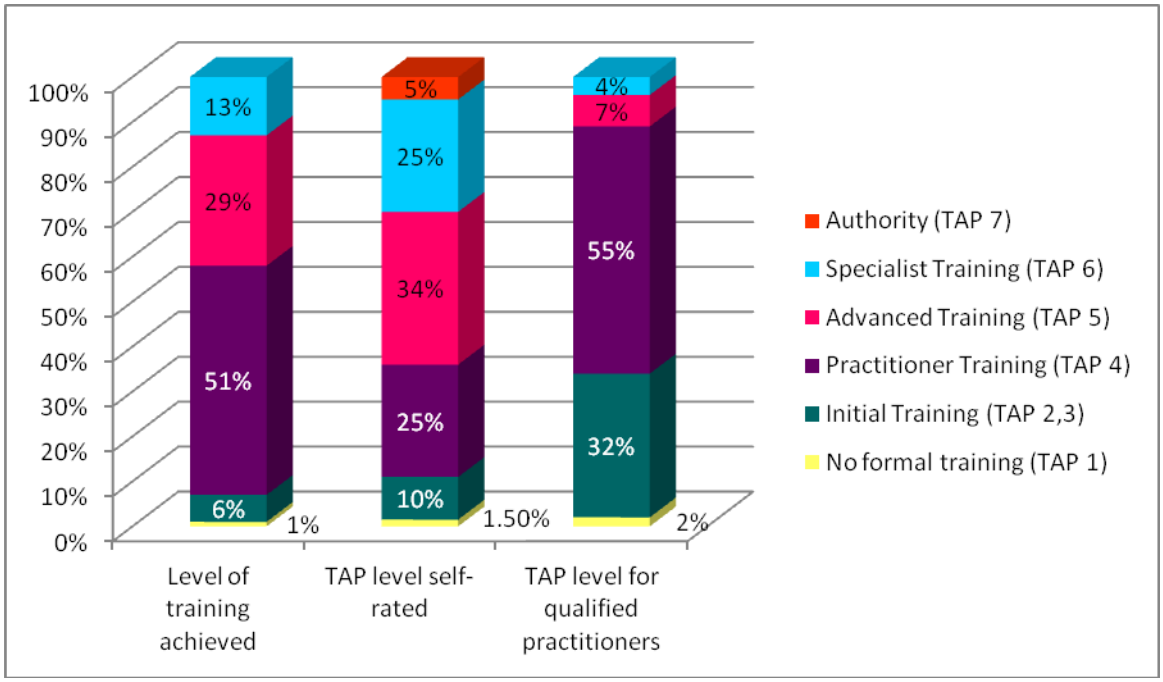

Figure 5.34: Practitioner training and T.A.P. levels

Practitioners (n=170) responses for level of training received were mainly level 4 (51%, 87) and level 5 (29% (50), with a further 13% (22) at level 6, 6% (10) at level 2 and 3)

and 1% (1) at level 1. The levels for self-rating themselves in the present were more distributed amongst the levels (n=134) , with 34% (46 at level 4 and 25% (34) at level 3, together with 25% (33) at level 6, 5% (6) at level 7 and 9.5% (13) at level 2,3 and just 1.5% (2) at level 1. As can be seen in Figure 5.33, both these responses contrast with the responses for the T.A.P. level for qualified practitioners (n=130), with 55% (72) in level 3, 32% (41) at level 2, 2% (3) at level 1, together with 7% (9) at level 5 and 4% (5) at level 6.

For practitioner responses, an analysis was conducted to assess whether awareness or not of the H.NOS would have any influence on 'self-rating' responses. Here a chi-square test was attempted. However, this could not validly be conducted due to low expected frequencies.

For practitioner responses, an analysis was conducted to assess whether awareness or not of the H.NOS would have any influence on 'T.A.P. level at qualification' responses. It can be noted that a chi-square test was attempted, but could not validly be conducted due to low expected frequencies.

Comments from practitioners in the questionnaires include that they are "*not academic*" or are *"self-taught"* (5) consider themselves at foundation (1) diploma (10) or advanced (11) or in specialist practice (7). Others indicated they have a wider qualification such as hypno-psychotherapist (5) or took a module within another speciality (2).

5.3.9.1 Summary of Practitioner training and T.A.P. levels

Half of practitioners questionnaires responses for their level of training achieved T.A.P. level focused around level 4, with a further one third at level 5 and indicated an increase in T.A.P. levels for their present self-rated level, with a quarter at level 4, one third at level 5 and a further quarter at level 5. Their view as to which T.A.P. level a qualified hypnotherapist would fit indicated over half at level 4, with a further one third at level 2 to 3. Questionnaire comments supported questionnaire responses, indicating that a qualified hypnotherapist may attain a higher level with experience, and that a professional hypnotherapist may attain a higher level than a

qualified therapist. The perception of professionalism indicates that it is placed higher in the T.A.P. model. Generally, practitioner self-rated responses indicate an increase in T.A.P. level beyond their initial training, thus indicating perhaps the perceived influence of experience and possibly CPD training. Furthermore, these practitioners rated their training generally slightly higher in T.A.P. level average than the level they assign to qualified practitioners.

5.3.10 Researcher training and T.A.P. levels

Unlike the practitioners who were focused around level 4, researchers were more focused around level 6 (Figure 5.35).

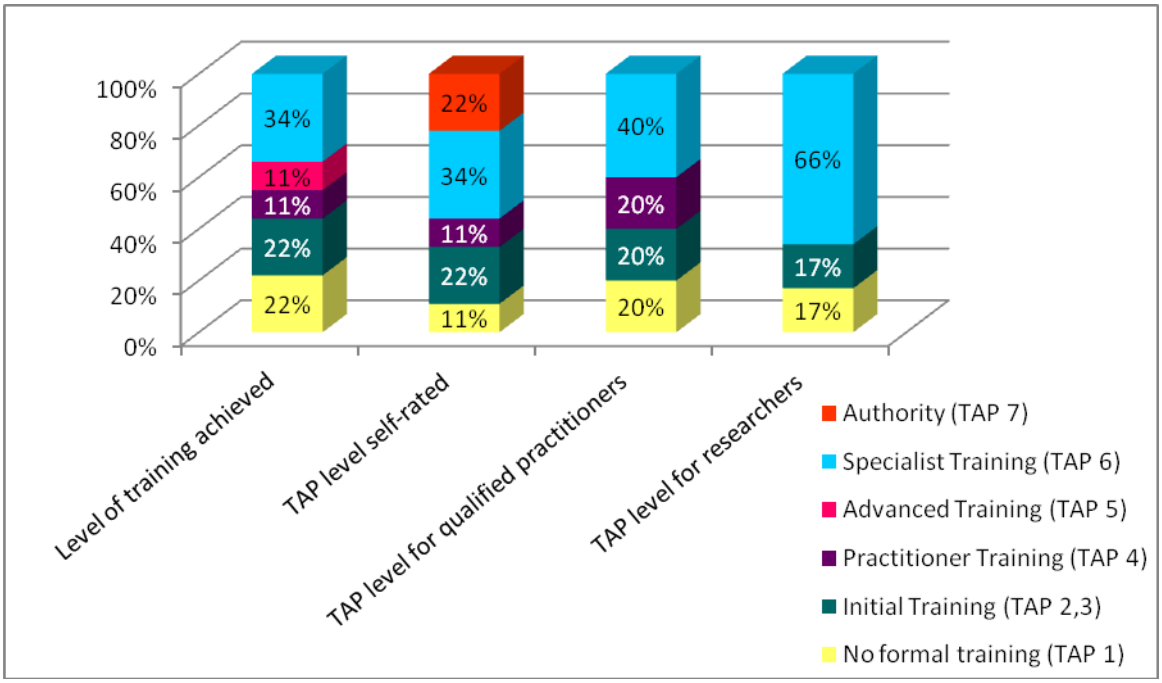

Figure 5.35: Researcher training and T.A.P. levels

The researchers (n=9) were divided in the T.A.P. level of training achieved, with 34% (3) in level 6, and the remaining spread between level 1 (22%, 2) and level 2and 3 (22%, 2) as well as 11% (1) for each of levels 4 and 5. It can be noted that the T.A.P. level for self-rating also had 34% (3) at level 6, although 22% (2) at level 7, 11% (1) at level 1, 22% (2) at levels 2 to 3, and 11% (1) at level 4. Of the five researchers who indicated a view on the T.A.P. level for qualified practitioners, 40% (2) indicated level

6, with 20% (1) in each of level 1, 2-3 and 4. Slightly more researchers (n=6) responded to the T.A.P. level for researchers and this clearly indicated 66% (4) considered level 6 most appropriate, with 17% (1) in level 1 and in 2-3 (Figure 5.35).

Only one researcher added a comment to their questionnaire response, indicating, *"use only for research"*. It would seem that this researcher only uses hypnosis during their research activities.

5.3.10.1 Summary of Researcher training and T.A.P. levels

Level 6 was the focus for around one third researchers as level of training achieved, self rated level, and level for qualified practitioners, with the remainder considering level 6 as the T.A.P. level for researchers, with other responses distributed mainly between the lower T.A.P. levels except for T.A.P. level self –rated where just one fifth of respondents considered themselves at level 7. Only one researcher commented in the questionnaire indicating they use hypnosis only for research. For level of training, self-rating, and researcher level, researchers (one third) mainly focused on level 6, with the remainder at lower levels, apart from a fifth indicating a level 7 for self-rating. No comments were made indicating how or why researchers rated their T.A.P. levels at these points.

5.4 Participant characteristics

5.4.1 Draft H.NOS Stage

5.4.2 Sufficiency of launch publicity

5.4.3 Initial source of awareness

5.4.4 Accreditation (membership of professional body)

5.4.5 Participation in CPD

The key questions relate to the two research questions regarding the influence of H.NOS on teaching and learning and on professionalism. It is accepted that not all respondents may be aware of the H.NOS, nor may have 'connected' with or engaged with the H.NOS if they were not included in the initial draft and launch. Furthermore, how respondents found out may influence their perceptions of the importance and

relevance of H.NOS. Respondents were also asked whether they were members of professional bodies, and whether they engaged in CPD and thus 'in the loop' for ongoing communications relating to H.NOS.

It is acknowledged that the consultation process for the H.NOS at draft stage was limited, with a high number of practitioners indicating they would have commented, had they been afforded the opportunity. Furthermore, the launch publicity was seen to be generally insufficient to reach all four respondent groups. It can be noted that generally, all four respondent groups have membership of professional hypnotherapy organisations and that practitioners and researchers participate in CPD.

5.4.1 Draft H.NOS stage consultation

As noted throughout this section, many respondents were unaware of the H.NOS either at the early stages of their development, or, for some, until recent times, or even this research. Several factors can be explored for their potential influence on respondents, from their potential contribution at the draft stage, the sufficiency of the launch process, how they initially gained awareness, if they did, together with whether they are accredited by any organisation and whether, for practitioners and researchers, they participated in continuous professional development (CPD).

All four respondent groups were surveyed to ascertain their contribution to the draft stage of the H.NOS. Both practitioners and researchers were generally unaware of the H.NOS at draft stage, with educators divided in whether they commented. It can be noted that professional bodies mainly commented (Figure 5.36).

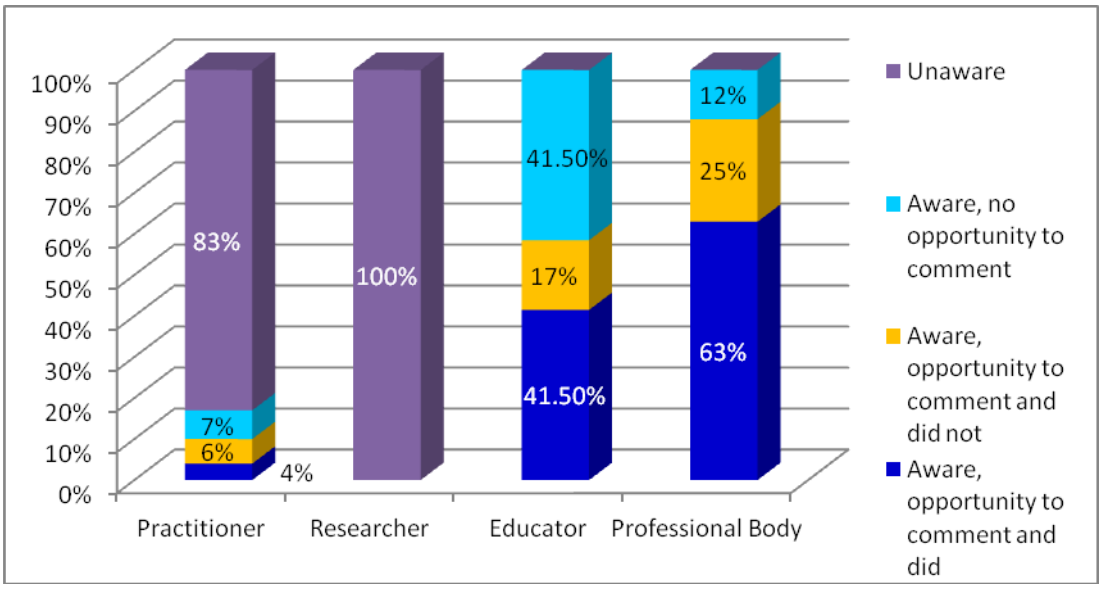

Figure 5.36: Draft H.NOS stage

The practitioners (n=184) were predominantly unaware (83%, 152) with those who were aware of the draft stage being divided between those with no opportunity to comment (7%, 13) those who did not use their opportunity to comment (6%, 11) and those who did comment (4%, 8). In contrast, none of the researchers (n=12) were aware of the H.NOS at draft stage. The educators (n=12), all of whom indicated they were aware of the draft stage, were divided between no opportunity to comment (41.5%, 5) and those who did comment (41.5%) with only 17% (2) of respondents not using their opportunity to comment.

For practitioner responses, an analysis was conducted to assess whether awareness or not of the H.NOS would have any influence on responses. A chi-square test was performed with responses summarised and recoded to 'would have', 'would not have' and 'did or did not'. Awareness or not of the H.NOS and actions on the draft H.NOS was analysed. Some 67% (*f*=54) of those not aware of the H.NOS (n=80) would have commented on the draft H.NOS, with some 33% (*f*=26) indicating they would not have commented and none indicating they did or did not comment. This compared with 55% (*f*=57) of those who were aware of the H.NOS indicating they would have commented and 27% (*f*=28) indicating they would not, with 19% (*f*=19) responding that they did or did not.

A chi-square analysis of the frequencies between aware/not aware and the draft H.NOS actions showed a significant difference, χ^2 (2, *N*=184) = 16.30, *p*<.001. The effect size was small with *phi* = .298 (Figure 5.37)**.**

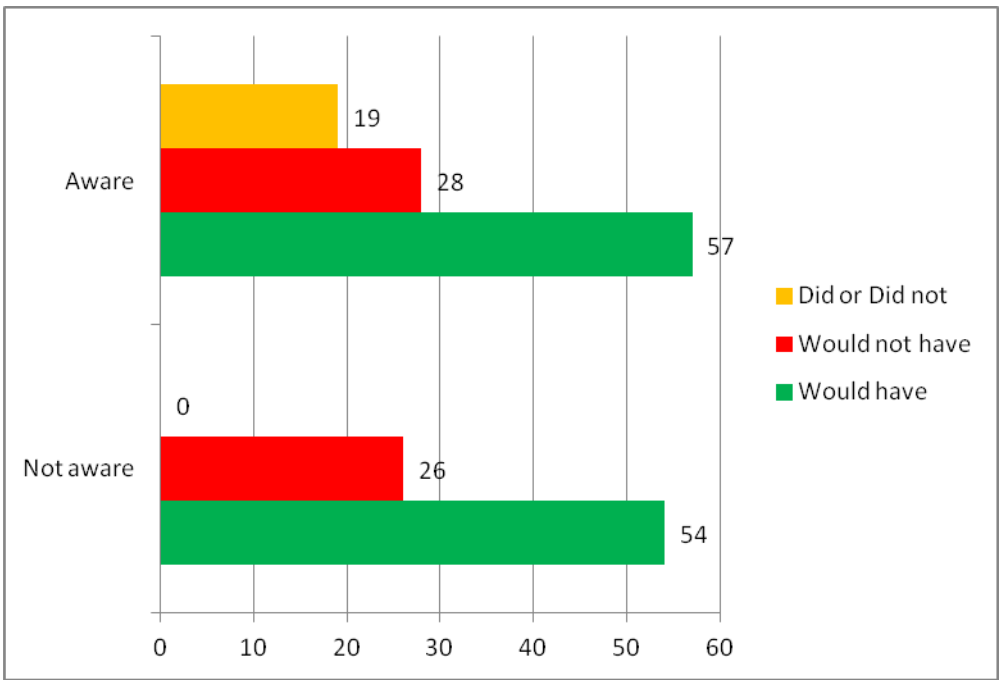

Figure 5.37: Awareness of the H.NOS and H.NOS draft action frequencies of response

Practitioner comments in the questionnaire mainly supported their selections, although some (5) indicated they were not in practice at the time and some (2) highlighted that they were not aware of the H.NOS. Educators' comments included a view of "*don't know"* (1) that "*only selected bodies invited"* (1) and that "*representation is vital"* (1). Furthermore, some (5) were not in practice at the time. Professional body comments included that they had participated (2) and "*not invited"* (1).

5.4.1.1 Summary of draft stage consultation

The questionnaire data indicates that practitioners and researchers were mainly unaware of the H.NOS at draft stage. Educators were mainly divided, with just under half ranged between no opportunity and did comment, and professional bodies generally had the opportunity to comment and with around two thirds who did comment. A chi-

square test which looked at those who were and were not aware of H.NOS and whether they would have commented found that two thirds would have commented. Comments in the questionnaires indicated limited opportunities to comment. Overall, it would appear that the consultation process for the H.NOS at draft stage was not widely known and that, for practitioners, had they been aware, a large proportion indicated that they would have commented.

5.4.2 Sufficiency of launch publicity

The practitioners and researchers were strongly focused in their view that the launch publicity was not sufficient, whereas both educators and professional bodies were closely divided in whether it was or was not sufficient (Figure 5.38).

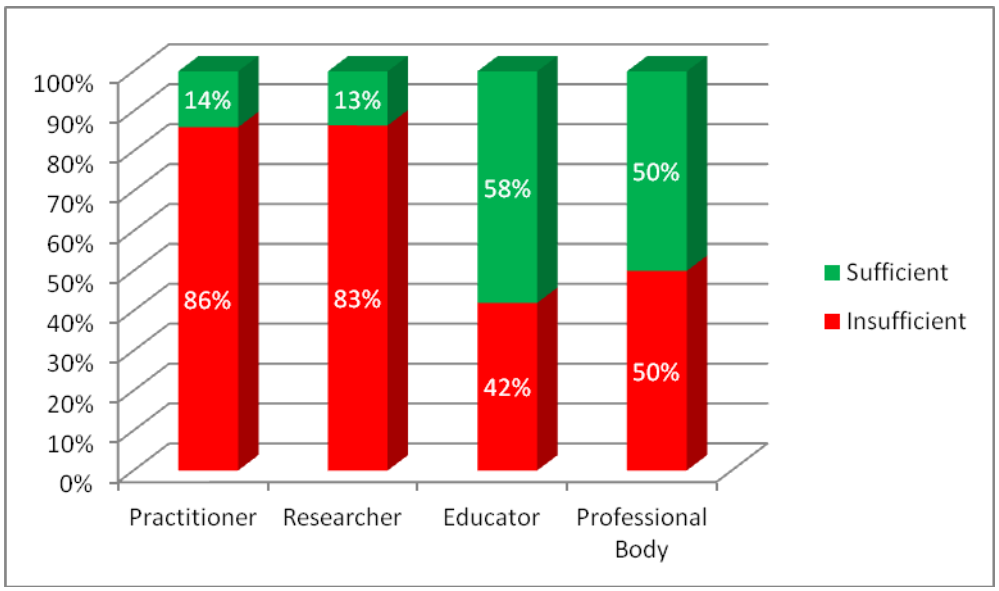

Figure 5.38: Sufficiency of launch publicity

Of the practitioners (n=185) and researchers (n=12) only 15% (25) and 17% (2) respectively, found the launch publicity sufficient. Whereas, for educators (n=12) and professional bodies (n=8) 58% (7) of educators and 50% (4) of professional bodies found it sufficient.

For practitioner responses, an analysis was conducted to assess whether awareness or not of the H.NOS would have any influence on responses. A chi-square test was performed. Awareness or not of the H.NOS and the sufficiency of H.NOS launch

publicity was analysed. Some 1% (*f*=1) of those not aware of the H.NOS (n=79) found there was sufficient launch publicity, with 99% (*f*=78) finding it was insufficient. This compared with 23% (*f*=24) those who were aware of the H.NOS (n=106) finding the publicity sufficient and 77% (*f*=82) finding it to be insufficient.

A chi-square analysis of the frequencies between aware/not aware and the sufficient/insufficient publicity showed a significant difference, $\chi^2(1, N=185) = 17.70$, $p<.001$. The effect size was medium with *phi* = .309. Figure 5.39 indicates that although there are more 'sufficient' responses in the aware category than the not aware, both aware and unaware generally consider the publicity to have been insufficient.

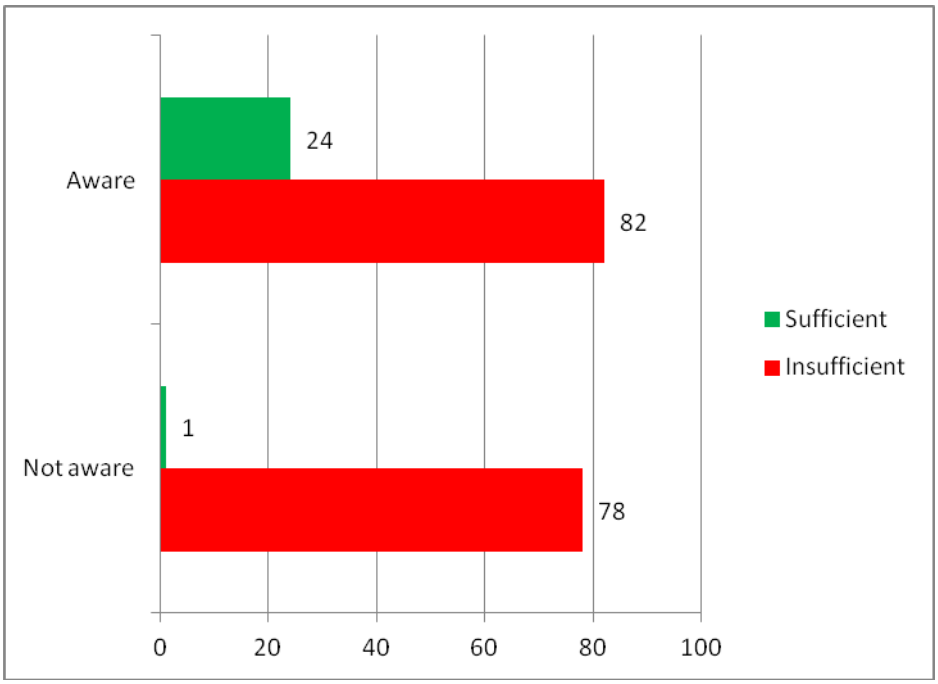

Figure 5.39: Awareness of the H.NOS and launch publicity

There were a large number of comments made in the questionnaire surveys by the practitioners (113). These mainly focused around views relating to a "*general lack*" (68) and "*restricted publicity*" (37), although a small number (4) found it to be broad or sufficient Researchers comments (4) indicated that either they had not heard (3) or that publicity was not wide (1). The educators (7) responded that they did not know (2) or

were unsure (1) or that publicity was not wide (3), although one indicated that publicity had been via their professional body (1).

5.4.2.1 Summary of sufficiency of launch publicity

A high proportion (80%) of practitioners and researchers found the launch publicity insufficient, with educators and professional bodies almost evenly divided between sufficient and insufficient. A chi-square test indicated both practitioners aware of the H.NOS and those unaware of the H.NOS considered the launch publicity to be insufficient. The questionnaire comments generally supported questions responses and were mainly focused around the lack of publicity. Overall, it can be concluded that the launch publicity was generally insufficient to capture all four respondent groups

5.4.3 Initial source of awareness

The respondents were divided in their view of initial source of awareness. Around half of the practitioners and researchers did not know about the H.NOS. Awareness for practitioners, educators and professional bodies mainly came from 'professional/ trade/consultative bodies' for practitioners, whereas the source was mainly 'general media/peers/others' for researchers (Figure 5.40).

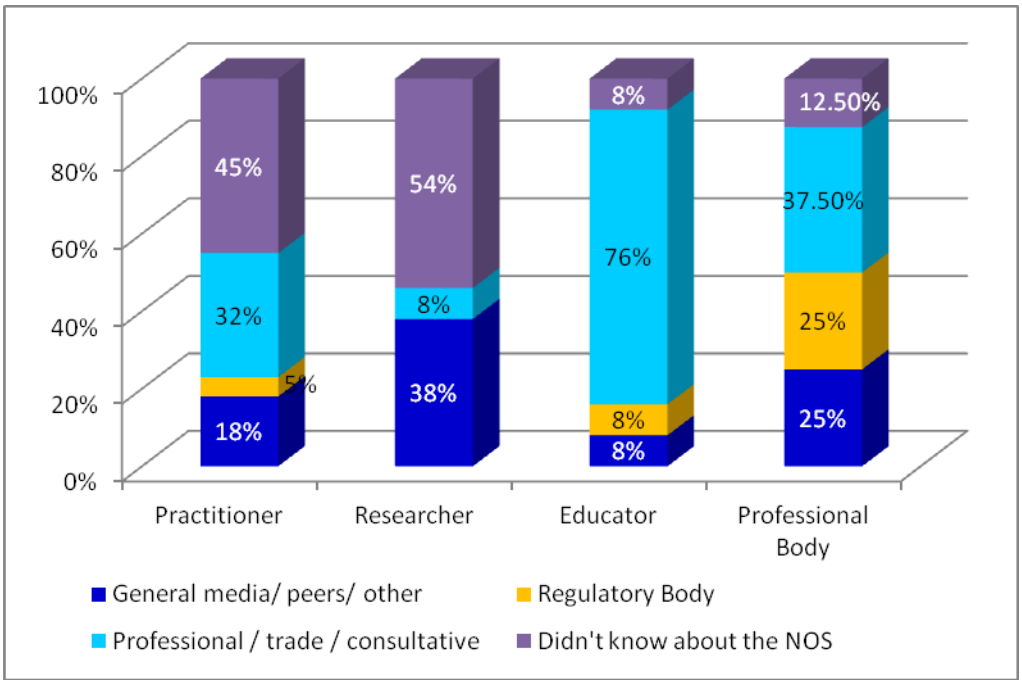

Figure 5.40: Initial source of awareness

The practitioners (n=185) were mainly divided between not knowing about the H.NOS (45%, 82) and professional / trade / consultative bodies (32%, 59), followed by general media / peers / others (18%, 34) and regulatory bodies (5%, 10). Researchers (n=13) were less divided, with 54% (7) not knowing about the H.NOS, only 8% (1) finding out from professional / trade / consultative bodies and 38% (5) finding out from general media / peers / others. The educators' (n=13) source of awareness was predominantly from professional/ trade/ consultative bodies (76% (1) with just 8% (1) of respondents finding out from each of regulatory bodies, general media / peers/ others and not knowing. The professional bodies (n=8) were divided in their source of awareness, with 12.5% (1) not knowing about the H.NOS and the remainder being divided between professional / trade / consultative bodies (37.5%, 3) regulatory bodies (25%, 2) and general media / peers / others (25%, 2).

Supplementary comments made by practitioners in the questionnaire survey indicated that the questionnaire survey was a source of awareness for 2 respondents. Students' tutors were a source for 5, with another 2 finding out as a result of "*personal fact finding*". Furthermore, for educators, 1 found out from another school and 1 from a professional body. Whereas for professional bodies, 1 gained awareness as a result of networking, 1 from another professional body and 2 were involved in the writing of the H.NOS.

5.4.3.1 Summary of initial source of awareness

The questionnaire responses indicated that around half of the practitioners and researchers did not know about the H.NOS, of those that did, the source was varied between professional organisations and the general media and peers. Educators main source of awareness (around three-quarters) was from professional sources as was just over half of the sources for professional bodies. The questionnaire comments added little extra, although tutors were a source of information for 5 practitioner respondents. Overall, it would seem that practitioners and researchers were divided in awareness of the H.NOS, with sources divided between professional and other. For educators and professional bodies, their sources were generally professional.

5.4.4 Accreditation

The majority of all four respondent groups indicated that they were accredited. The practitioners, researchers and educators being accredited by a hypnosis / hypnotherapy professional body, the educators further being accredited by a professional body and the professional bodies being accredited by a regulatory body.

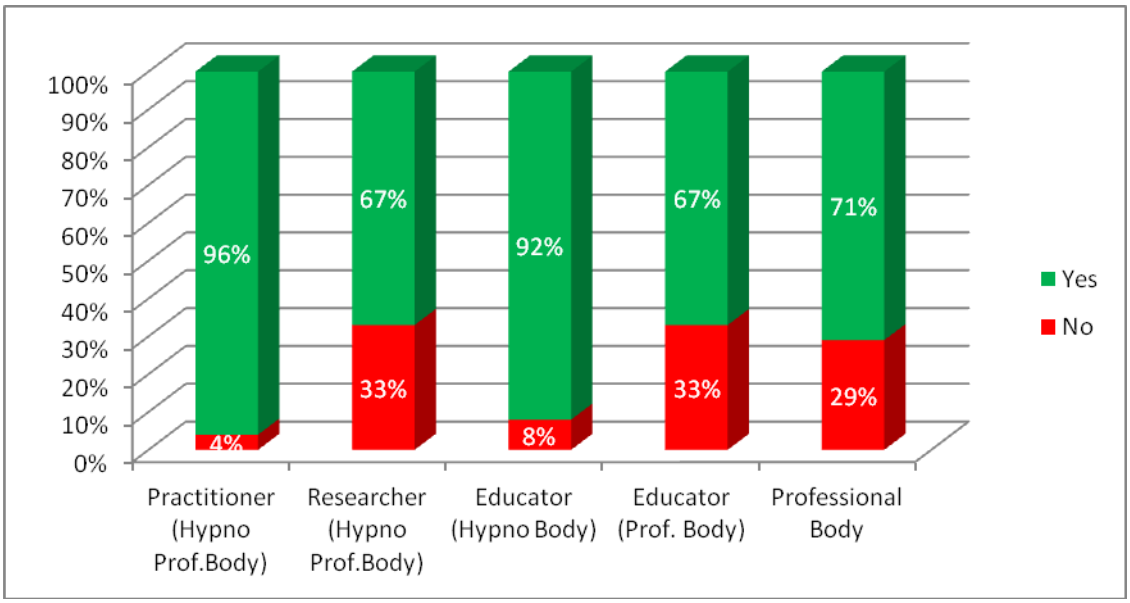

Figure 5.41: Accreditation

Use of hypnosis / hypnotherapy professional body accreditation was indicated by 96% (159) of practitioners (n=166), 67% (6) of researchers (n=9) and 92% (11) of educators (n=12). These educators also indicated 67% (8) were accredited by a professional body. Furthermore, 71% (5) of professional bodies (n=7) were accredited by a regulatory body.

For practitioner responses, an analysis was conducted to assess whether awareness or not of the H.NOS would have any influence on responses. A chi-square test was attempted, but could not validly be conducted due to low expected frequencies.

Supplementary comments (12) made by in the questionnaire surveys indicated views that accreditation was good for the profession / professional status / conduct (6) and that professional membership indicated conduct (3), although 3 indicated that they don't recognise / don't need / or accreditation is not relevant for them.

5.4.4.1 Summary of accreditation

Almost all practitioners and educators and half of researchers had membership of a hypnotherapy professional body, with 7/10th of professional bodies also having appropriate professional membership. Questionnaire comments generally supported accreditation. Overall, it would appear that it is common practice for those surveyed to hold professional membership.

5.4.5 Participation in CPD

Almost all practitioners and two thirds of researchers indicated that they participate in CPD (Figure 5.42).

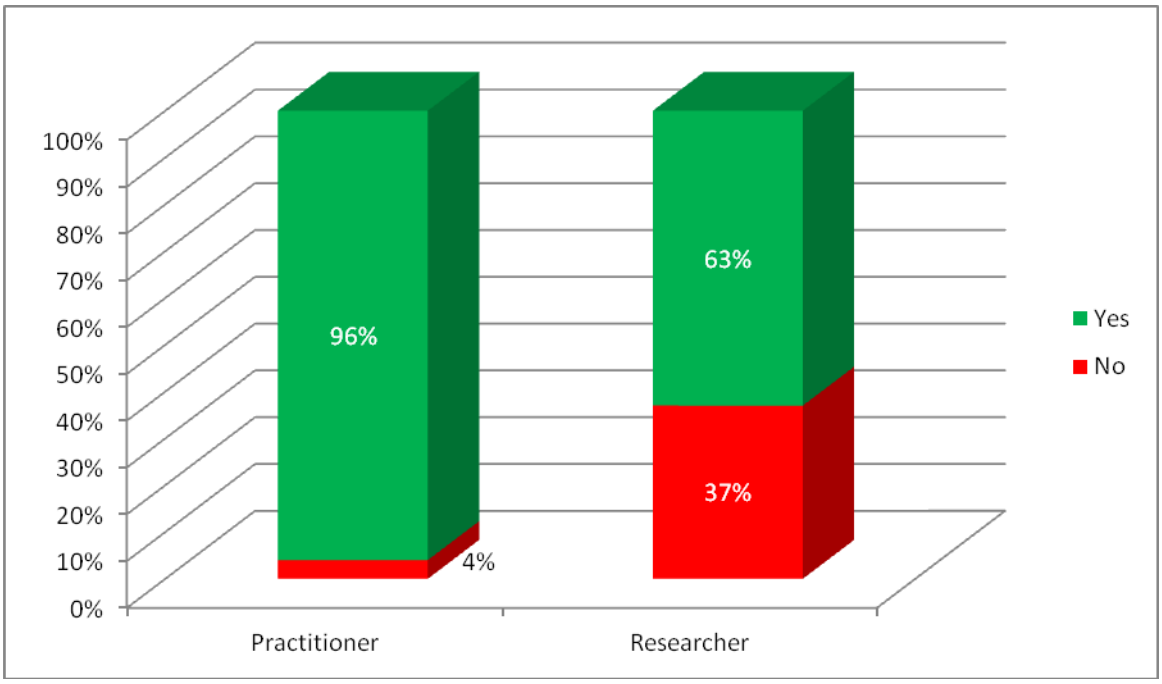

Figure 5.42: Participation in Continuous Professional Development (CPD)

Of the practitioner respondents (n=169), 96% (162) indicated that they participate in CPD, with 64% (5) of researchers (n=8) also indicating participation. For practitioner responses, an analysis was conducted to assess whether awareness or not of the H.NOS would have any influence on responses. It can be noted that a chi-square test was attempted, but could not validly be conducted due to low expected frequencies.

Summary of participation in CPD

In conclusion, almost all practitioners and two-thirds of researchers participate in CPD.

5.4.6 Additional comments

At the conclusion of the questionnaire, all respondents were given an opportunity to add further comments to their questionnaire survey responses. These comments ranged between factual, positive and negative perceptions, yet with no single specific theme. There were no comments made by researchers. For the practitioners responses (n=48) these ranged from negative (32), to positive (9) and 8 other (8) comments. Negative comments included not 'knowing enough about the H.NOS (17), that they don't go far enough (8), or may impair individual professional practice (2), other commented that practitioners may over-estimate competence (1), the NOS needs to issue accreditation (1), there is a need for a single regulatory body to raise profile of the profession (2) or that they disagree with the H.NOS (1). In contrast, the positive comments mainly indicated a view that the H.NOS contribute towards professionalism (5) are needed to raise professionalism (1), contribute toward training standards (2) and that participants can progress through each stage of the T.A.P. model (1). This is echoed by a view of a spread of development over several T.A.P. levels (2) a need for practitioners to be able to work independently (1) or that the NOS have not reached the width of the profession (2) or have other, unrelated views (2).

For educators, the questionnaire comments indicated a view that H.NOS are essential for standards (1), yet H.NOS should avoid over professionalization (1). However, there was also a view that not all therapists have the depth of training to work independently of scripts (1) and that, for one educator, they considered their standards in-house are higher than the H.NOS.

Professional bodies contributed few additional comments in the questionnaires, the two were divided between a view that the H.NOS was a *"benefit for the regulatory body rather than the profession"* and that there was insufficient time since the H.NOS was introduced to assess the real influence.

5.5 Overview of a selection of respondents from each questionnaire group

A random selection of respondents was taken from each of the four groups to provide an overview of the respondents in more detail.

Practitioners

A practitioner who did not know about the H.NOS (*"never heard of it"*), was also unaware of the draft and would have commented. They regard their present training level to be 'specialist' and participate in CPD. However, they do not know if their training met H.NOS and thus whether it was important for that training to have met the H.NOS was not applicable. They did respond that they consider the H.NOS as having been a positive influence on teaching and learning. Although they had professional membership, they were unaware of any changes that their professional body made to meet H.NOS criteria. The H.NOS were considered to reflect the general professional competence standards and commented they "*would give people confidence*". However, they considered them to have had no influence upon competence standards in the UK nor had any influence upon the perception or extent of professionalism, indicating a view that *"people don't know about it"*. Finally, they self-rate their training at T.A.P. level 5, consider the H.NOS reflects level 5 and that qualified practitioners should fall within this level.

Another practitioner found out about the H.NOS from their training school and did not find the launch publicity sufficient, indicating, "*My family and friends only know about NOS because I discussed it with them"*. They were aware of the draft stage and would have commented if they had had an opportunity. This practitioner considers themselves at specialist level, indicating a 30-year history of counselling to support their hypnotherapy work. Their training met the H.NOS and they considered it important for training to meet this, indicating, *"I personally want to offer my clients the best professional service I can and I want clients to feel safe when accessing therapists"*. They do view the H.NOS as having had a positive influence on teaching and learning, although suggest it is *"probably too soon to tell what the influence is, but initial discussions with colleagues are positive"*. A practitioner who has professional body membership, was not aware of any changes their professional body made in response to H.NOS, but did undertake additional training as a result of H.NOS and found it beneficial. They regarded the H.NOS as meeting the minimum professional competence

standards, below that of the organisation where they studied. They do indicate a view that the H.NOS have had no influence upon professional competence standards, further commenting, *"I sincerely hope the long term effects will be to raise standards. I'm particularly concerned about the weekend courses that tell people they are competent to practice"*. They go on to indicate that although they consider the H.NOS have had a positive influence on the perception of professionalism, they have had no influence on the extent, commenting it is "*too early to tell what the extent of professionalism will be"*. Finally, they self-rate their T.A.P. level at 6, with the H.NOS considered to sit at level 4, and that this was also the appropriate level for a qualified hypnotherapist.

Another practitioner respondent found out about the H.NOS from their professional body, although considered the launch publicity to be insufficient, commenting, *"I don't think the general public are aware of them"*. Although they were aware of the draft stage and had an opportunity to comment, they did not. The practitioners consider themselves as advanced level, participate in CPD, had training that met H.NOS and consider it important for training to meet H.NOS. They did not consider there to have been any influence on teaching and learning although "*not clear as did not know what it was like before"*. Although they have membership of a professional body, they were unaware of any changes made to meet H.NOS. They regard the H.NOS as reflecting the minimum professional competence standards and having had no influence upon professional competence, perception or extent of professionalism. They do self-rate at T.A.P. level 3 and consider qualified hypnotherapists should be located at T.A.P. level 4.

Researchers

One of the researchers that had not heard of the H.NOS, also considered the publicity insufficient *"because I've never heard of it"*. They consider themselves at 'practitioner' level, that they do not know if their training met H.NOS and do not find it important for training to do so, commenting, "*I did not know of NOS (which was probably nonexistent at the time)"* and having no influence on training and learning. They consider themselves at T.A.P. level 7 and find this appropriate for researchers, although did not indicate where they find H.NOS would sit.

Curiously, another researcher indicated in their responses that they were aware of H.NOS, having found out from the general media and they were aware of the publicity, although were not aware of the draft stage and would have commented. Then they did not comment any further throughout the questionnaire, it is unclear why.

For another researcher, they also found out about the general media, although did not find the launch publicity sufficient, commenting, "*hypnotherapy and psychological therapies and training are generally misunderstood and not enough communication is offered to the public"*. They indicate they were unaware of the draft and would have commented and that their level of training is 'specialist'. They did not know whether their training met the H.NOS, it was prior to H.NOS, and indicated it was not applicable with regards to any importance for training to meet H.NOS. They also responded that the considered the H.NOS to have had no influence on teaching and learning. They do regard the H.NOS as reflecting the minimum professional competence standards and having had a minor positive influence on competence and a positive influence on perception and extent of professionalism. For the T.A.P. model, they self-rated at level 6, put the H.NOS at level 3, qualified practitioners at level 4 and researchers at level 6.

Educators

The one educator (of 17) not aware of the H.NOS did not consider there was sufficient launch publicity indicating, "*I was not aware of them"*. It can be noted that this organisation had only recently commenced training. They indicate not using the H.NOS as criteria for entry or practitioner training, but for advanced, specialist and CPD training. Interestingly, they also consider it important for training organisations to meet H.NOS for entry and practitioner training. This is clearly contradictory and, in an interview situation would have benefited from further exploration, particularly as they have responded that they consider the H.NOS have had no influence in training design, provision or student learning. They consider the H.NOS represent the minimum professional competence standards in the UK and lower than those of their professional body. Furthermore, that they have had no influence on the perception or extent of professionalism. Their final comment indicated, "*The trend towards academic accreditation may lead towards some very well qualified, but inadequate therapists. NOS should strive to maintain a lay perspective in order not to follow counselling into over-professionalisation*".

In contrast, an educator who was aware of the H.NOS considered there was sufficient launch publicity, contributing *"It would be better if information came to all hypnotherapists direct but as the NOS committee doesn't have contact info for all therapists this would be impossible. The next best thing is for them to give it out to all relevant Hypnotherapy professional membership organisations, which I believe they do and for those organisations to pass this on to their members. Both my organisations do that"*. This educator had the opportunity to comment on the draft, and did do so *"...because they felt representation was vital"*. They indicate finding use of the H.NOS important for training from entry to CPD, indicating, "*If these standards are expected to be met by the industry, then they should be conveyed to those we train*". However, it is noted that they consider the H.NOS to have had no influence on teaching and learning although they commented, "*we already met all criteria without the NOS having to outline them, since they seem obvious criteria to me as owner of a training school. That having been said, it is still important that the NOS do outline standards, as some training bodies may not be currently aware of them or meet them"* They do indicate a belief that the H.NOS represent the minimum professional competence standards which are at the same level as their professional body.

Furthermore, this educator indicated a view that the H.NOS have had a major positive influence on professional competence and "*because there is limited jurisdiction and regulation within the hypnotherapy field, even a minimum reflection of professional competence standards generates a major positive influence since going from very little to a little bit more is a big leap. As time progresses, of course, bigger measures will obviously be necessary to have a major influence"*. Perception and extent of professionalism questions both received 'positive influence' responses. When considering training and the T.A.P. model, they indicated that whilst their training reaches level 4, and training for a practitioner should be at level 4, that the H.NOS is at level 1, commenting, "*Any training should create a level of competence within students to practice as proficient independent professionals, with the relevant amount of supervision according to experience. No independent practitioner should take on clients at an intermediate level or below unless they are fully supervised when doing so – i.e. for highly supervised practice for training purposes"*.

Another educator found out about the H.NOS from one of the professional bodies. Although they did comment at draft stage, they do not use the H.NOS to inform any training from entry to CPD as *"we have our own criteria"*. This is further supported by their indication that it is not important for training to meet the H.NOS and that these standards have not influenced training design, provision or student learning, commenting "*we already have high standards in all these things, and have no interest in NOS influence"* also "*we have no interest in other organisations*". This educator considers the H.NOS represents the minimum competence standards and lower than those of their organisation, with the H.NOS having had a minor negative influence upon professional competence and no influence on perception and extent of professionalism. Perhaps the most diverse views can be noted for responses to questions relating to the T.A.P. model The educator considers their training for practitioners is T.A.P. level 7 (Authority) and that this is the appropriate level for a qualified hypnotherapist. However, they declined to answer where the H.NOS fit into the model.

Professional bodies

The single professional body (of 8) not aware of the H.NOS also considered there was not sufficient launch publicity. They considered there was no influence on teaching and learning. Although they made no changes to training standards from entry level to specialist, they did make changes to standards for CPD training. However, they indicated this was due to a CNHC requirement, thus not directly associated with the H.NOS. They indicate they have not made changes to training at H.NOS launch as they were unaware of the H.NOS and this is why they do not presently use the H.NOS for any training criteria as specified in the questionnaire. However, they do consider it important for all training organisations and professional bodies' training from entry level through to specialist and CPD, to meet the H.NOS indicating, *"I think a unified standardisation across the profession is to be welcomed"*. They considered the H.NOS had no influence upon teaching and learning, although commented that they were unaware of the H.NOS. This PB declined to answer the questions relating to the T.A.P. levels.

One professional body who indicated they are aware of the H.NOS was involved in the H.NOS writing process alongside Skills for Health. However, even they consider that there was sufficient publicity at the launch. They do suggest there were many changes

at Skills for Health at this time, also that "*a lot of professionals consider NOS to not be relevant as very basic level"*. They show not changing any existing standards initially for entry to CPD training. They only indicate presently using H.NOS to inform entry-level training, demonstrating they only consider it important for all professional body's entry-level training criteria to meet H.NOS. Furthermore, they indicate that they consider that the H.NOS has had no influence on teaching and learning. They do consider the H.NOS represent the minimum professional competence standards and these are a lower standard that their own professional competence standards. In addition, they consider the H.NOS have had no influence upon the perception or extent of professionalism. They indicate their T.A.P. level is 3 for their practitioner training and that H.NOS represent T.A.P. level 2 and that a professional hypnotherapist should achieve level 4. When asked for comments, they indicate a view that they are "*aimed at fulfilling the requirements of SK4H* (Skills for Health) *than the profession"*.

Another professional body found out about the H.NOS from a professional body and did consider the launch publicity to be sufficient. They had the opportunity to comment on the draft and did utilise this opportunity. Furthermore, they amended their training from entry to CPD to reflect the needs of H.NOS and presently use the H.NOS to inform such training, considering it important for all professional bodies and educators to use the H.NOS to inform their training. They also consider the H.NOS have been a positive influence on teaching and learning. Indicating, "*All courses that lead to practitioner registration within the main registering organisations now require inclusion of NOS*". Furthermore, despite considering they offer a lower standard than that of their own organisation, they revised their professional competence standards for membership in response to H.NOS indicating "*our understanding is that NOS were always intended to reflect minimum professional competence standards, particularly as they are essentially separate from the Core Curriculum, CPD and Supervision"*. They are accredited / have professional membership of a range of organisations. They do consider their "*our minimum requirements for practitioner level registration include both NOS and the agreed National Core Curriculum"*. This professional body considers the H.NOS to have had a major positive influence upon professional competence standards, and positive influence of perception and extent of professionalism.

6. DISCUSSION

6.1 Introduction

The aim of this research has been to conduct an analysis of the influence of the H.NOS on hypnosis and hypnotherapy teaching and learning, and professionalism. This was considered important as the H.NOS and associated Core Curriculum inform practitioners, educators, professional bodies and the public regarding skills and knowledge necessary for competent practice of that specific occupation. It was unknown whether the H.NOS had high awareness within the hypnotherapy sector, nor whether the standards were influential, positively or negatively. Importantly there was found to be no other similar research since the time of the draft and launch of the H.NOS to the present. The direction of this research was influenced by the researcher's experiences during her initial training and ongoing professional development. As can be observed in the Introduction (chapter one) and Literature Review (chapter two), the hypnosis and hypnotherapy sector is diverse and not subject to statutory regulation. It was questioned whether in some parts of the hypnosis and hypnotherapy sector that the H.NOS were known or whether they had resulted in any positive contributions to teaching and learning of hypnosis and hypnotherapy for new entrants to the profession and for ongoing development (CPD). It was also considered whether the H.NOS had resulted in any positive influence on perceptions of professionalism within the groups surveyed.

Four groups within the hypnosis and hypnotherapy sector were surveyed: firstly, practitioners who use hypnosis and hypnotherapy with clients and patients; researchers who use hypnosis and hypnotherapy for research purposes; educators who teach hypnosis and hypnotherapy and finally professional bodies that set professional competence standards and educational standards that are followed by the practitioners, educators and possibly the researchers, although this is more closely regulated by research ethics. This post-positivist study, sought predominantly quantitative data using questionnaires, supported by qualitative textual data from the questionnaire comment boxes. The data from the 250 respondents was analysed in the Data Analysis (chapter four).

Analysis of the data presented in the preceding chapter (chapter four) indicated that the H.NOS have had a positive influence on both teaching and learning and professionalism, with awareness or otherwise of the H.NOS particularly influencing responses for practitioners. Contributing to these findings were several key points that will be discussed, together with how the outcomes relate to the issues raised in the introduction and literature review chapters. The few methodological issues encountered will also be discussed. This leads into a summary of the discussion. The final chapter (chapter six) provides a conclusion and presents the final recommendations.

6.2 Key findings

Teaching and learning

There was evidence of positive perceptions of the influence of H.NOS on hypnotherapy teaching and learning. However, there are notable differences between practitioners and researchers as learners and 'end-users', and between educators and professional bodies as providers of training and definers of standards. It is important to note that around half of researchers and practitioners were unaware of the H.NOS. Both practitioners and researchers predominantly found launch publicity to be insufficient, despite having professional membership and engaging in CPD.

Practitioners

Just under one half of the practitioners (43%) found the H.NOS had been a positive influence on training design, content, provision, teaching and student learning. Questionnaire comments indicate a general lack of awareness of the H.NOS or possible influence.

Half of the practitioners were unsure whether their training met the H.NOS. Furthermore, half of the practitioners considered it important for training to meet H.NOS for initial and practitioner level training, slightly less for higher level and CPD training. A notable division was observed between practitioner aware and not aware of H.NOS in their responses regarding importance with those aware generally finding it important, and those not aware much less strongly focused on importance. Comments were divided between a lack of awareness or relevance and that it was beneficial to have standards. It can be observed that awareness, or not, of the H.NOS has influenced

practitioner responses regarding teaching and learning, with those aware generally finding the H.NOS a more positive influence on teaching and learning, and with those unaware of the H.NOS, not finding this so. Although both groups generally found it important for training to meet H.NOS, for those aware this was notably greater. Practitioners were moderately positive about the influence of H.NOS on teaching and learning, and about the importance of training meeting H.NOS, with evidence indicating those aware of the H.NOS were most positive than those unaware.

Researchers

Only one-third of researchers considered the H.NOS relevant to themselves as researchers and this may have influenced their responses throughout the questionnaire, although possibly more so for teaching and learning, as it would be anticipated that most research is conducted with ethical approval and thus professional conducted expected. The researchers generally did not recognise any positive or negative influence on training design, content, provision, teaching and student learning. Over half of the researchers were unsure whether their training met H.NOS. Most researchers did not know if it was important for training to meet H.NOS. One-third of researchers considered H.NOS relevant to researchers, lacked firm views on the influence of H.NOS on teaching and learning, were unaware of whether their training met H.NOS and did not know if it was important for training to meet H.NOS.

Educators

Half of the educators (48%) found the H.NOS had been a positive influence on training design, content, provision, teaching and student learning. Most educators considered it important for training to meet H.NOS, although less strongly focused above practitioner training level, although this is little reflected in their responses relating to the use of H.NOS as criteria for standards and training. Whilst half used it for initial and most for practitioner training, importantly between half and three-quarters of educators used H.NOS to inform training above practitioner level. Of those educators who made changes in response to H.NOS, around half felt this added benefit. Educators indicated they were positive about the influence of H.NOS on teaching and learning, and more strongly focused on the importance of training meeting H.NOS.

Professional bodies

Of the professional bodies, (58%) found the H.NOS had been a positive influence on training provision, teaching and student learning, with a stronger response towards positive for training design and content, although with comments made around lack of awareness. All professional bodies considered it important for initial training to meet H.NOS and most for other levels of training. However, this is not reflected in their use of H.NOS for specialist or CPD training, although it is for lower levels of training. Around half of the professional bodies indicated having revised their professional standards to meet H.NOS and, despite almost all indicating they informed educators of these changes, only a quarter of educators were aware of the changes. This can be interpreted with caution due to the low numbers (n=8) of professional body respondents. Comments made were generally positive towards standards, although indications were made towards relevance at some levels. Thus, professional bodies had a positive view of the influence of H.NOS on teaching and learning, strongest for training design and content, and viewed it as more important for the early levels of training, to practitioner, to meet H.NOS.

Professionalism

It was found that respondents considered the H.NOS had a positive influence upon professionalism, although this was a milder response than for teaching and learning. As for teaching and learning, there are differences between the respondents. It is relevant to note that around half of researchers and practitioners were unaware of the H.NOS.

Practitioners

For teaching and learning, practitioner responses towards H.NOS were more positive from those aware of the H.NOS, than for those not aware. Around one-third of practitioners generally considered the H.NOS as having had a positive influence on the perception and extent of professionalism. However, looking deeper, responses were a mirror image between those aware and not aware of the H.NOS with around one-third of those aware finding the H.NOS to have a positive influence on perception of professionalism, and two-thirds of those unaware. Thus, the perhaps ‘naive’ view was heavily influencing the group response. Overall, this would indicate a slight positive influence at best. However, such mirror opposition was not observed in the inferential test for extent of professionalism with those aware of the H.NOS almost equally divided

between no influence and positive influence, whereas a notable majority of those who were unaware considered it to have no influence. Thus, both sub-groups were stronger in their view toward no influence. There were more negative than positive comments, although recognising that positive benefits could develop in the future. Overall, any positive influence is 'stronger' for perception than extent of professionalism.

Practitioners were divided in their views on the H.NOS influence upon Professional Competence Standards (PCS) with half finding no influence, and the remainder a positive influence. However, considering separately those aware and not aware of the H.NOS, those aware were mainly of the view of a positive influence, whereas those not aware were predominantly responding that there was not a positive influence. Comments were generally of a negative nature and indications that the H.NOS were not widely adopted or of sufficient depth or breadth. The H.NOS reflection of PCS for practitioners was divided between minimum and general PCS in the UK, although numerous practitioner comments indicated they had no real knowledge of the H.NOS. Few practitioners were aware of changes made by their professional bodies in response to H.NOS, although those who undertook further training found it beneficial.

Practitioners' perceptions of where the H.NOS best fits into the T.A.P. model were widely distributed, yet mainly level 3 and 4, although some comments indicated this could depend on qualifications and experience. Practitioners' level of training achieved was reported as mainly between levels 4 and 5, and self-rating their present level between levels 4 and 6. However, the view was that a 'qualified' practitioner would sit at levels 3 or 4. This indicates that the T.A.P. model appears to accurately reflect respondents' views relating to levels of training. Furthermore, it would appear that practitioners consider they have developed beyond their qualification training, perhaps as a result of CPD training, development and experience.

It can be observed that there are considerable differences in responses between those practitioners aware of the H.NOS and those not aware. This was particularly noticeable with the influence on PCS, with those aware finding it a positive, and those not aware finding it having no influence.

Thus, practitioners consider that where there is a positive influence of H.NOS on perception and extent of professionalism, it is more so for perception than extent, and that there is a mild positive influence upon PCS. With the H.NOS representing between the minimum and general PCS in the UK, they are considered to fit into levels 3-4 on the T.A.P. model, with these practitioners between 4 and 6 and qualified practitioners perceived to be levels 3 to 4.

Researchers

The researchers had a similar view to practitioners, with a little over one-third finding the H.NOS as having had a positive influence on the perception and extent of professionalism. Just under a third of researchers found the H.NOS to have had a positive influence on PCS and researchers predominantly considered the H.NOS reflected the minimum PCS in the UK. Very few researchers were aware of changes made by their professional bodies in response to H.NOS, although they did undertake further training. Researchers perceptions of where the H.NOS best fits into the T.A.P. model distributed between levels 1, 3 and 5 and their level of training achieved was widely distributed between levels 1 and 6, together with self-rating their present level between levels 1 and 7. However, the majority of views indicated a 'qualified' practitioner would sit at levels 4 or 6, and a researcher predominantly at level 6. It would appear that researchers consider a high level of performance is required for researchers.

Researchers were mildly positive of the influence of H.NOS on perception and extent of professionalism, with a view that the H.NOS reflect the minimum PCS. However, whilst they reported widely distributed T.A.P. related levels of training and self-reporting present levels, they considered qualified practitioners should achieve between levels 4 and 6, with researchers at level 6.

Educators

Educators' responses regarding the influence of the H.NOS on the perception and extent of professionalism demonstrated just 20-30% finding it a 'positive' influence. Furthermore, 10% indicated H.NOS had resulted in a negative influence on the extent of professionalism. This was not further supported by comments, although it may be questioned whether the educator respondent who considered H.NOS was at basic level

and thus reduces the depth of training required, in their view, for a professional. Almost half of educators considered H.NOS as having had a positive influence upon PCS, although two of the eleven respondents considered it a negative influence. Comments included a lack of uptake in training schools. Educators generally considered the H.NOS reflected minimum PCS in the UK and that was mainly the same as their own PCS, yet comments indicate uncertainty as to whether they do or do not reflect PCS.

Educators' perceptions of where the H.NOS best fits into the T.A.P. model were widely distributed, although mainly related to levels 1 to 3. Comments from educators indicate training should create independent competence, yet supervision can mitigate for its lack. Educators were also divided both as to where their training sat on the T.A.P. model (levels 1, 3, 4, 7), and where qualified practitioners should be placed (1, 4, 5, 7), with most responses being between level 3 and 4. Few educators regarded the H.NOS as having had a positive influence on the perception or extent of professionalism, although a moderate number viewed there to have been a positive influence on PCS, with a view that the H.NOS represent the minimum PCS in the UK and reflects their own levels of PCS. The H.NOS were considered to be located within T.A.P. level 4, with qualified practitioners reaching between levels 3 and 4.

Professional bodies

Over one-third of the professional bodies considered H.NOS to have had a positive influence on the perception and extent of professionalism. Almost half of professional bodies considered H.NOS as having had a positive influence upon PCS with the remainder focusing on no influence. The H.NOS reflection of PCS was predominantly minimum PCS in the UK, although a majority considered their PCS were higher than the H.NOS. Professional bodies did make changes to their standards and training criteria in response to H.NOS, mostly for practitioner training, but also focusing on initial and CPD training.

Professional body perceptions of where the H.NOS best fits into the T.A.P. model were widely distributed between levels 1 and 5. Professional bodies were also divided both as to where their training sat on the T.A.P. model (levels 1, 3, 4, 6), and where qualified practitioners should be placed (1, 3, 4, 6), with most responses between levels 3 and 4.

6.3 Reflections on the Introduction and Review of Literature

Teaching and learning

The H.NOS would appear to influence both initial teaching and learning, and ongoing training. It can be considered that professional bodies set and disseminate the standards for the hypnosis and hypnotherapy profession. For practitioners to achieve these standards, training criteria are determined which will enable these standards to be met. For the H.NOS to have had any influence upon teaching and learning, it would be expected to have influenced these criteria. Professional bodies who participated in this research indicated a positive perception of the influence of H.NOS on teaching and learning, strongest for training design and content, finding it as more important for the early levels of training, to practitioner, to meet H.NOS. Educators were also positive about the influence of H.NOS on teaching and learning, and the importance of training meeting H.NOS.

As end-users of the training standards and provision from these bodies and organisations, practitioner respondents were also positive about the influence of H.NOS on teaching and learning, and the importance of training meeting H.NOS. However, researchers were generally unaware of any influence of H.NOS on teaching and learning.

It is apparent from the Review of Literature chapter that hypnosis education in the UK is diverse, ranging from single day training courses to those taking several years, together with the use of books as teaching instruments, DVD‘s and online training. It can be recognised that some brief courses, such as a long weekend, are advertised as ‘practitioner training’ and other longer courses, such as over four months, are advertised as ‘entry level’. Such variation can be confusing for those entering the hypnotherapy sector (Mills, 1996:49) and, as yet, there appears to be no single source of information providing unbiased, factual information about entry requirements.

Furthermore, Buchanan and Hughes (2000:98) consider that the teacher’s role during training can be considered as crucial and it would seem appropriate that educators of hypnotherapy students are well informed about H.NOS. However, not all educator respondents indicated a thorough knowledge. Furthermore, some did not consider it

important for their training to meet H.NOS at any level between initial training and CPD.

Budd and Mills (2000a) indicated that there appeared to be a lack of consensus of educational standards and practice. There certainly appears little agreement amongst educators as to what constitutes 'practitioner' training. Furthermore, the varied responses of educators in this survey may indicate differences in perspectives as to the benefit, importance or otherwise of training meeting H.NOS, together with the associated core curriculum. Whilst it is recognised that some established organisations far exceed the criteria of H.NOS, this is rarely commented upon in their publicity material, thus making it difficult for prospective students to make informed choices as to the extent of training, the knowledge and understanding, and even the extent of practical work that all can be contributory towards an overall competence. Such diversity continues through to CPD training, which can be of varied quality, depth and relevance.

The White Paper on CAM regulation (House of Lords Science and Technology Committee, 2000, s.6.1) indicated a need for high quality accredited training, whilst recognising present training (at the time of the White Paper) as being varied in content, depth and duration and it can be considered that this is as true today. The H.NOS outline the performance outcomes in terms of knowledge and skills for hypnotherapists. The associated Core Curriculum indicates, in broad terms, what needs to be taught to individuals to enable them to achieve these performance outcomes. Current discussion by practitioners at networking events, conferences and forums presently appear to be around the requirements for reflective practice, CPD, and clinical supervision. Whilst practitioners generally will be aware of the latter two, the concepts of reflective practice do not appear to be widely and explicitly discussed during all training. This does not imply that reflection does not take please but that practitioners do not ascribe a label to that action.

The concepts of verifiable or validated training, as recommended in the White Paper for CAM Regulation (House of Lords, Science and Technology Committee, 2000, s.6.25) may offer clarity to those regulating, providing and seeking training at all levels from initial training through to CPD. The CNHC has indicated in recent newsletters that they

are considering a validation process. Such training would most likely be linked to the H.NOS and core curriculum and thus provide a benchmark for training comparison. Presently, training organisations tend to be recognised by one or more professional associations or bodies. However, it can be questioned whether the CNHC has the support of all the professional bodies, as the Professional Standards Authority of Health and Social Care (PSA) indicate that not only have the CNHC expressed an interest in joining the Accredited Voluntary Register (AVR) but so have some of the larger professional bodies. It can be noted that all healthcare regulation will sit under the PSA.

As can be observed in Chapter two, Section 2.8, Budd and Mills (2000a) found professional associations complicated. Some organisations accept members from a range of institutions or qualification level, others only from a linked training organisation. This can be partly observed in the questionnaire responses of the professional bodies, with one of the eight not even being aware of the H.NOS and only half finding the launch publicity sufficient, or having commented on the draft. The influence of the H.NOS on professional bodies appears to have been varied, with only some considering it important for training to meet H.NOS and being divided in opinion of its influence on teaching and learning, competence and professionalism. However, most concur that the H.NOS represent the minimum professional competence standards. It is perhaps curious then that there is such a division in its applicability as previously mentioned.

Professionalism

It can be viewed that professionalism within the profession is influenced in two directions, from the professional bodies towards practitioners, and from practitioners to the public.

Professional bodies found the H.NOS a positive influence on professionalism, including perception, extent and professional competence standards (PCS), although some consider the H.NOS represents a standard lower than their own. This can be demonstrated by the number of changes that professional bodies indicate they have made to their standards and training criteria. For educators, the H.NOS has also offered a positive influence, although educators regard their PCS as similar to the H.NOS.

Thus, both groups of organisations who influence practitioners and researchers find the H.NOS a positive influence. This is carried through to practitioners and even researchers although to a less comprehensive effect.

The appeared no indication within the practitioner questionnaire responses as to whether practitioners were medical or lay hypnotherapists, nor was it asked about the environments in which they worked and with which client or patient sections. Thus, it is not possible to assess whether either sub-group would be more or less aware of any influence of the H.NOS on teaching, learning or professionalism.

As mentioned in the Literature Review (chapter two), the CNHC appears to reflect of the values of the White Paper (House of Lords. Science and Technology Committee, 2000) on regulation of the health professional, although, as it indicates, with its key role of being protective of the public, it would not appear to be as focused on promoting professionalism to practitioners as promoting safety. It could be argued that there are subtle differences between the two, in that a professional must work safely, but to work safely you do not have to be professional. Furthermore, considering once again the Miller and Rose (1990) interpretations of 'government' of professional practice 'at a distance' and at the lack of awareness of the H.NOS, amongst the profession and the public, it is to be wondered whether this distance is, at present, a little too great. More prominent government support of NOS in general and H.NOS particularly may generate public awareness and it is from the public that the hypnotherapy students of the future are located. Furthermore, public awareness may then inform the selection process when seeking a therapist and market forces will generate a shift towards engagement of therapists with H.NOS, either leaving those without to retire, or up-skill. Whilst some respondents' questionnaires responses indicated concerns regarding the H.NOS leading to over-regulation, Fonagy (2010) has the view that H.NOS will not affect the magic. It could further be suggested that the H.NOS will enable the magic to be carried, with a more professional standard!

It was suggested in the Literature Review (chapter two) than an aspect of professionalism is that of a moral community (Durkheim 1992/1950) contributing to social stability (Dingwall and Lewis 1983, Perkin 1989). It could be considered that with this survey's evident positive perceptions of the influence of H.NOS on

professionalism, that both the lay and medical hypnotherapy professions may join together in following the criteria of H.NOS. Whilst each sub-group may keep their different roles within the overall position, a common standard can only benefit the public and those within the profession.

T.A.P. model

NOS are described by Skills for Health as indicators of best practice, describing what a competent person should do, know and understand. For hypnotherapists, and those for whom the H.NOS and associated Core Curriculum are relevant, this can be seen to represent the theoretical and practical skills, knowledge and understanding required to use hypnotherapy with patients and clients. However, neither the H.NOS, nor the associated Core Curriculum give any indicate of the extent of these attributes. This can make it difficult to evaluate training provision, outcomes and development as a professional.

The T.A.P. model arose as a condensed summary of teaching, learning and professionalism models, after finding there appeared no single model that would map against the NOS criteria for action, knowledge and understanding for a competent, or professional, individual. The seven T.A.P. levels may be regarded as progressive, from (1) beginner, (2) novice, and (3) intermediate, to (4) practitioner, (5) senior practitioner, (6) specialist and (7) authority. The T.A.P. model employs a grid of six factors under two heading of thoughts (knowledge, understanding and decision-making) and actions (skills, communication and behaviour). Together, these factors could be considered to represent a degree of professionalism.

Although views from all four groups were distributed across several T.A.P. levels, and particularly for the H.NOS and T.A.P., the consensus put the T.A.P. levels for qualified hypnotherapists between levels 3 and 4, with researchers at level 6.

No group found one single T.A.P. level best represented the H.NOS, and there can be a number of explanations for this. Firstly, that the H.NOS is practical in orientation and does not easily map to the more conceptual aspects of the T.A.P. model. Secondly, that there is a lack of awareness of H.NOS both completely and in detail, thus making it

more difficult for respondents to compare the H.NOS to the T.A.P. model. It could also be that there are elements of the H.NOS that would best map to one part of a T.A.P. model level and other elements to another T.A.P. level and this was suggested by one respondent. The practitioners and researchers completed different levels of training and self-rating. These were perhaps challenging to map to T.A.P. (as evidenced by the diverse responses), as were educator and professional body views of their own training criteria. This again can be due to the differences between a practical course and a conceptual model. However, it could also be that different aspects of their training met different aspects of the model, with no single T.A.P. level accounting for all of them. Although, a consensus did find agreement that training for 'practitioners' would fall between level 3 and 4. These are the categories associated with intermediate (level 3) and practitioner (level 4). Furthermore, researchers considered researchers should be located at level 6 (specialist).

6.4 Methodological issues

In the Methodology (chapter three), the intended approaches in terms of paradigm, approach, instruments and ethics were explored and described in the manner that they were intended to be used. This section explores how those intentions were met and discusses any diversions from the plan and the reasons for those.

Methodological approach

Throughout the research, the post-positivistic approach was the defining research paradigm for this predominantly quantitative post-positivist study, allowing for the combination of mainly quantitative and some qualitative data, whilst striving for objectivity (Burgess *et al*, 2006). It can be suggested that for research endeavouring to gain both factual information, such as levels of training, which is objective (Swetnam, 2000) and perceptual information, which is subjective, this is the most appropriate route and can lead to triangulation of results (Hammersley, 1996). On reflection, the post-positivist approach has enabled this study to gain the most relevant data to be analysed in response to the research questions. The relatively objective quantitative data from the questionnaires has enabled statistical enquiry and the qualitative data from the questionnaires tended to support respondents questionnaire responses, thus adding an element of triangulation and added overall depth to the study.

Methods

As has already been mentioned in 6.4.1, the survey method was successful in being the most appropriate approach for the targeted groups within the hypnotherapy sector (practitioner, researcher, educator and professional body).

Instrument - Questionnaire

The primary instrument for data collection was the questionnaire survey that gained primarily quantitative categorical (nominal) data, with respondents frequently having the opportunity to add comments to support their selections and thus being qualitative in nature.

During perusal of the Data Analysis (chapter four), it may be observed in the data reports that not all participants answered each question. 'Forced responses' are possible with Survey Monkey (the online questionnaire host) which inhibits progression without completion of a question. However, this was so disliked at the start of the process that the 'forced response' coding was removed. Consequently, not all questions were answered, including some of the participant demographics, although all responded they agreed to participate in the survey. There are clear advantages in terms of comprehensive data collection by having forced responses, thus enabling complete data sets. However, it is considered that this may have resulted in respondents simply exiting the questionnaire, particularly as far more practitioner respondents than anticipated were unaware of the H.NOS. On balance, the decision to operate the questionnaire on an 'optional completion' basis could be seen as supported by the number of skipped responses scattered throughout the questionnaires which otherwise may have resulted in early exiting from the questionnaire.

It was clear, particularly for practitioners that not all respondents were aware of the H.NOS and inferential tests highlighted that the responses differed, often considerably, between those who were and were not aware. Had the questionnaire provided a link to the H.NOS this may have resulted in more individuals responding from an informed perspective, as opposed to some perhaps going by the best estimation or personal view.

Bell (2005) suggests it is easier to analyse a well-structured questionnaire and care was taken with layout and structure. What did work particularly well was the ability to

download the data directly into Excel and the statistical software, SPSS version 20. This ensured that there were no input errors.

Recruitment of participants

It took far longer than anticipated to gain sufficient numbers of responses. The request for participation was originally launched in May 2012 and published in the CNHC newsletter.

A request was also e-mailed to all professional bodies listed on their website. The professional bodies were asked to complete the survey and disseminate the questionnaire to their member training organisations and practitioners. By October 2012 there were less than 80 total responses. Individual training organisations were emailed asking them to both complete the survey and disseminate the questionnaires. All earlier email requests were repeated and all UK universities contacted and asked to disseminate the survey links to researchers using hypnosis. Furthermore, the past fifteen years of Contemporary Hypnosis Journals (based in UK) were reviewed, the UK-based researchers' names noted, and where they had a UK e-mail were contacted. Data collection by questionnaire survey concluded at the end of January 2013.

Generalisability of sample to population

There is no single source of information that can quantify the population numbers for each of the four respondent groups. Initial investigations for practitioners found professional bodies reluctant to release membership numbers. Furthermore, therapists can be members of several organisations. A survey of all those hypnotherapists who advertised in the Yellow Pages, and found 1155 hypnotherapists (Northcott, 1996). However, these are perhaps only the most 'professional' and do not account for the 'hobbyist' or part-timer who sees a couple of clients in their living room at home, although the 'snowball sampling effect' may have resulted in some 'outliers' gaining access to the questionnaires. For researchers this is again challenging to quantify. Some researchers use hypnosis only once or twice in their career almost as a by-product association of their research, whereas others use it more regularly. It is estimated (using anecdotal information) that there are around 50 researchers using hypnosis or hypnotherapy in the UK. It would seem simpler to gain numbers of educators, although there were around 100 listed on various professional body and advertising websites.

These range from individuals who offer one day (or less) training courses, up to the large and professional organisations, some of whom are progressively gaining more academic recognition, such as the MSc. in Clinical Hypnotherapy at University of West London. Professional bodies also range in size and prominence, ranging from large organisations representing many professional hypnotherapists, to small organisations who may only represent the graduates of a single small training organisation. It is estimated that there are around 25 professional bodies in the UK, with Budd and Mills (2000a) finding seventeen at the time of their research.

In conclusion, it is considered that the entire sample (n=250) is moderately representative of the population. However, caution can be observed as only those practitioners, educators and professional bodies that have connections such as professional membership will have been reached by the requests to participate. Whilst some researchers may also have been reached by this route some may not have, nor be known to the universities or other institutions contacted individually.

Ethical issues

There were no major unforeseen ethical issues. Several respondents used names in their comments in the questionnaires comment sections, and these have been removed to maintain anonymity. One respondent did email, suggesting that I offer a fee for completing the questionnaire. This was declined for ethical reasons. It would seem completely unreasonable to offer an incentive to a single respondent and could call into question the validity of their responses. Furthermore, this could be regarded as a separate group of one respondent as they were treated differently from the others. It was a deliberate decision not to offer any incentives, as it was regarded that those who then responded were more likely to give their true views, avoiding any possible reciprocity effect, with completion focused on what it is perceived the researcher is looking for, which may arise with the prospect of a reward.

Limitations of the approach

As the study progressed and particularly during the analysis of data potential limitations of the study arose and were noted.

On reflection, it would have been useful to ascertain the date that the participants and researchers first gained their qualifications as this would have indicated whether they were in practice at the time of the H.NOS draft and subsequent launch.

It could be suggested that the questionnaire question format, which resulted in categorical data, could have been differently designed, such as with the use of Likert scales. This would have offered a wide range of statistical analysis, together with a broader choice for the respondent. However, on balance, it was considered scaling may only have been relevance for a few of the questions and may have diluted the data unnecessarily for little gain on more 'yes /no' or 'positive / none / negative' type questions.

Had wider resources been available, fuller triangulation could have been achieved with widespread semi-structured interviews (such as 10% of each group). These could have been assigned before the questionnaire for some respondents, and after the questionnaire for other respondents to avoid response order effects. Although comment boxes were used by many participants, some in depth, more detailed interviews would have added greater depth to the study.

6.5 Discussion summary

The key findings indicate that there were positive perceptions of the influence and influence of H.NOS. Differences occurred between the practitioners and researchers, and between educators and professional bodies. In addition, differences were observed between those practitioners aware and those not aware of H.NOS. Practitioners were moderately positive of the influence of H.NOS on teaching and learning whereas researchers were generally unaware. Educators were more strongly focused on importance of training meeting H.NOS and professional bodies had a positive view on teaching and learning, particularly finding it important for early training to practitioner level to meet H.NOS.

For the influence of the H.NOS on professionalism, there was a mildly positive perception of influence of H.NOS. Practitioners were more positive of influence of H.NOS on perception than extent of professionalism and having a mildly positive influence upon PCS. Researchers had a similar view, although to a lesser extent. The educators were less positive on the perception and extent of professionalism, although considered a moderately positive influence on PCS. However, professional bodies were more positive about the influence of H.NOS on professionalism, including the perception and extent, and moderately positive about influence on PCS.

When reflecting on the topics arising in the earlier Introduction (chapter one) and Literature Review (chapter two), from a teaching and learning perspective, the government White Paper (House of Lords Science and Technology Committee, 2000) indicates a need for accredited / validated training. Presently, professional bodies currently recognise some educators training, and the CNHC is looking to validate training. However, training in the UK is diverse, with little comparability between educators' content, duration and depth of training, despite indicating in the research that they find it important for their training to meet the H.NOS, which has an associated Core Curriculum.

From a professionalism perspective, it is not known whether practitioner respondents were medical or lay hypnotherapists. However, as the voluntary regulatory body, the CNHC considers public safety one of its key roles; comparable training would help this and draw together the hypnotherapy community.

Furthermore, from a professionalism perspective, the T.A.P. model was created with an aim to help benchmark training. Generally, the consensus for practitioner training was for it to sit between level 3 and 4, with researchers considering they were best met by level 6. No group mapped directly for any of the T.A.P. questions, with influencing factors including the lack of H.NOS awareness, and that training may map to separate parts of the T.A.P. models on different levels.

Finally, from a methodological perspective, a post-positivist approach defined the paradigm for this predominantly quantitative study, using the survey method, with questionnaires as the instrument. Due to the size of the sample as compared to an

estimate of the population, it is considered that there is generalisability of the sample to the population, although practitioners who are not members of professional bodies, such as 'hobbyists' may not have been captured, unless by snowball sampling effect. However, the sample is more representative of the population of the other three groups, despite low respondent numbers. Finally, there were no notable unforeseen ethical issues.

7. CONCLUSIONS AND RECOMMENDATIONS

7.1 Aims and objectives

This research analysed the influence of H.NOS upon hypnosis and hypnotherapy teaching and learning, and professionalism in the UK. In doing so, it engaged with four key groups within the hypnotherapy sector: practitioners, researchers, educators (training schools) and professional bodies (associations). Online predominantly quantitative questionnaires were the source of data collection from the 250 participants.

7.2 Research questions

This study has two research questions, both of which relate to the hypnosis and hypnotherapy sector and the H.NOS:

Research Question No.1: What influence have the H.NOS had on hypnosis and hypnotherapy teaching and learning?

Research Question No. 2: What influence have the H.NOS had on hypnosis and hypnotherapy professionalism?

7.3 Findings in relation to the research questions

Analysis of the data collected found that there was a positive influence of the H.NOS on teaching and learning, and a weaker positive influence of the H.NOS on professionalism. It was observed, particularly for practitioners, that there was a statistically significant difference in responses from those aware of the H.NOS to those not aware, with those aware generally more positive in their perceptions of the H.NOS.

7.4 Findings in relation to the literature

As has been discussed in the Literature Review (chapter two), hypnosis and hypnotherapy have evolved throughout a long and diverse history to its present role in

society. However, that role is still lacking clear definition, with differences between medic and lay practitioners and researchers, together with misconceptions about hypnosis persisting within the profession, in the wider healthcare professions and amongst the public. Training has evolved from a demonstrations and personal / informal tuition to more formalised and structured training, although again this varies immensely with training ranging from DVD-based or electronic book courses on EBay to a MSc. degree course. The lack of collective direction can be confusing for the public and those entering the profession, working within it (practitioners) and those teaching within in (educators) and those directing its focus (professional bodies). Training schools have evolved their training according to their own standards and philosophical approaches and professional bodies have built on these with similar standards, taking graduates from these training schools.

The government White Paper (House of Lords Science and Technology Committee, 2000) that focused on CAM made several recommendations with direct relevance to hypnotherapy. It indicated areas for development, including research skills and access to conducting research, therapy-related training and ongoing development. It noted the vast range of training present in CAM and the need for a more unified approach. In response to government initiatives the H.NOS were launched in 2002. These specify best practice in terms of knowledge, understanding and skills and in 2012 became supported by an associated core curriculum. The voluntary regulatory body, the CNHC, also established as a result of government initiatives, requires registrants to have training to the standard of the H.NOS. Thus, both educators and professional bodies need, it would be thought, to use these as the minimum standard within their training and standards. The findings of this research indicate that there is a definite lack of awareness of the H.NOS amongst practitioners and researchers. This is despite most having professional body membership and engaging in CPD (and thereby interacting with educators), although those who were aware found the H.NOS were important for teaching and learning. The educators and professional bodies were more aware of the H.NOS, although it would appear that they have not entirely adapted their syllabus and standards to reflect them. It would seem that there is a clear need for more awareness raising so that of all those who participate in the hypnosis and hypnotherapy sector are aware of the H.NOS. Such awareness may enable practitioners to reflect on their own

expertise and identify any areas of development. Reflective practice could be considered one of the attributes of a professional.

The findings in this research also indicate a positive perception of the influence of H.NOS on professionalism, again more powerfully for those aware of the H.NOS. Thus, again with increased awareness of H.NOS, there is a likelihood of increasing the influence upon professionalism within hypnosis and hypnotherapy provision. From a professional perspective, it can be asked whether the H.NOS deliver. They do set a standard for the CNHC, the voluntary regulatory body to work with, with those practitioners whose training meets the standards within the H.NOS (and now the associated core curriculum) eligible for registration. The government, and, in particular, the DoH, promotes CNHC membership, as does the NHS. As the largest healthcare provider in Europe, the NHS can be seen as a good 'standard-setter' or benchmark that the public can recognise. Furthermore, with the H.NOS requirement for CPD this promotes the ongoing development of practitioners to maintain and enhance their knowledge and skills. Together this can support Foucault's concepts of legitimacy (1979) and systems of control (1973, 1980) of autonomous subjects, exercising appropriate conduct including self-regulation and training of the self, by one-self (Foucault, 2000). In addition, it resonates with Friedson's perspectives of occupational control of work (Friedson, 1994, 2001) and with Fonagy's view (2010) of the systemisation of skills and knowledge.

Should there be a move in the future towards statutory regulation, the concepts of professionalism within a regulatory environment will have been established, thereby meeting one of the points raised in the White Paper on CAM (House of Lords Science and Technology Committee, 2000). However, other aspects mentioned within that White Paper, such as a single professional association, would seem less likely, due to the diversity and eclectic nature of hypnotherapy practice in the UK.

Professional significance

The significance of the outcomes of this research for practitioners is that it demonstrates that those who know of the H.NOS have positive perceptions of its influence on teaching and learning and professionalism. This indicates that other practitioners may also find it a positive influence. For researchers, the outcomes of this research

indicating that as the H.NOS offer something to practitioners and are being incorporated in their development and professional practice, is of great relevance. If research is to be applied in the 'real world', as reasonably, research relating to therapeutic approaches might, then it would seem appropriate for such research to fit within the H.NOS model to enable translation from research theory into 'real-world' practice. The outcomes of this research for educators are that the positive perceptions of practitioners indicate that the H.NOS is important for training. This is important if these educators want their training to meet H.NOS and enable students to become eligible for professional body membership and thus CNHC registration. This may lead to an increase in the public's perception of organisations' professionalism, which may be a positive factor in recruiting new students. The outcomes of this research for professional bodies lies in awareness raising, as if only some practitioners and few researchers are aware of H.NOS, there is a clear need for further raising of awareness of the H.NOS. Also, not all educators use H.NOS to influence training, so further awareness-raising is needed here if professional bodies are 'verifying organisations' for CNHC.

7.5 Original contributions to knowledge and practice and disseminations

Original contributions

This study has resulted in three significant original contributions to knowledge and practice:

Firstly, the Review of Literature examines and presents the literature, drawing together concepts and views, uniquely relating them to the research questions of this study;

A second contribution is the 'first of its kind' survey of the influence of H.NOS on teaching and learning, and professionalism, reaching 250 difficult-to-access practitioners, researchers, educators and professional bodies. As has been identified there is a lack of previous studies of the influence of H.NOS both in terms of teaching and learning, and professionalism. Furthermore, there have been few recent studies of the perceptions of hypnotists and hypnotherapists, researchers, educators and professional bodies, and none found that asked all four groups;

The third contribution is the creation and development of the T.A.P. model which maps to the H.NOS and has applications in screening, assessment, development and action planning, not only for hypnotherapy and other therapies, but more broadly as well (see chapter three).

Disseminations

It is anticipated that the research outcomes fill a gap in studies in the area of the influence of the H.NOS on teaching and learning, and professionalism, and dissemination will create a knowledge base in this field. Furthermore, that it will inform practitioners and researchers, educators and professional bodies of the current perceptions and views of the H.NOS on the topics of teaching and learning, and professionalism.

Broader dissemination of the outcomes of this research, and the recommendations resulting from it, are envisaged to have influence upon course design, provision and student learning, together with definitions of standards, and may even contribute towards the ongoing movement toward statutory regulation within the hypnotherapy sector.

Moreover, there are the wider disseminations and contributions to knowledge regarding the influence of NOS (generally), both for CAM and talking therapies, and for NOS, including H.NOS, as a concept or tool. In addition, the T.A.P. model, developed for this research offers wide dissemination opportunities in terms of a teaching, learning and development benchmarking or guidance tool.

Some interest in the outcomes of this research has already been received from the media, the CNHC, professional bodies and educators and a range of briefings may be required. Further potential sources of dissemination include hypnosis, psychology and education journals. Moreover, it is anticipated that the material in this thesis will guide and inform a book on teaching hypnosis and hypnotherapy. It will also inform the structure of a range of teaching courses and offer guidance to professional bodies in the UK and internationally.

7.6 Personal development

The process of this research has had an immense influence on my personal and professional development. In the early parts of the EdD programme, the requirements for disseminations of preparatory material for the research stage necessitated my having to have papers published in journals and be introduced to the world of conference presentations. I discovered a hidden skill (and passion) in presenting at conferences, and later for teaching, and have now developed these in the UK and internationally.

Furthermore, to deepen my knowledge of how hypnosis and hypnotherapy was taught, I participated in over one-thousand hours of training, and read in excess of 300 books. I gained much insight into what and how hypnosis and hypnotherapy is taught, as well as the secondary benefit of increasing my professional knowledge and skills, which now inform my professional practice and teaching approaches.

As many researchers appear to study hypnosis from a psychology perspective, I also undertook a MSc. Psychology, with my project on a 'cross-subject' topic of *''Anxiety and mindfulness influences on hypnotic suggestibility''*. This gave me insight into the challenges faced by researchers in academic environments.

7.7 Limitations of the research

Depending on perspective, all studies may have limitations. This study set out to gain the views of unknown populations of practitioners and researchers, and little quantified populations of educators and professional bodies. It can be observed that although 210 practitioners responded to the survey, there were low numbers in the other groups, although with little information regarding the population, it cannot be determined how greatly or minimally the study respondents represent the populations.

In addition to low numbers in some respondent groups, the study would have benefited from greater triangulation. Although the questionnaire comment boxes offered opportunities for textual, qualitative responses, the survey was predominantly quantitative. Semi-structured interviews, even of a percentage of the respondents, would have added greater depth to the data and may have provided greater insight, particularly for perceptual questions.

Within the questionnaire, the use of scaling, such as with Likert scales, may have provided more depth of data than the closed questions and responses utilised. It may also have provided more variety to the questionnaire design and enabled respondents to be more specific with their views.

7.8 Future research directions

It is suggested that there could be further research in several areas, to address questions that arise from this research. Firstly, it would be beneficial, following any further awareness-raising of H.NOS, to survey the hypnosis and hypnotherapy sector at a later date to determine any increase in awareness and any further influence on teaching and learning, and on professionalism. Furthermore, should there be significant amendments to the H.NOS planned in the future, then a future study may be more focused as an 'impact study', particularly where a measure can be obtained prior to amendments followed by a further measure taken after implementation of changes, thus gaining a clear indication of resultant impact.

The recommendations of this study do indicate further future research directions. It is anticipated that the T.A.P. model would benefit from wider research to ascertain its breadth of use in training and development. Moreover, it would also be useful to conduct a survey on the perceptions of the awareness and influence of any hypnotherapy NVQ. Additionally, it would beneficial for there to be a survey of hypnosis and hypnotherapy practitioners to establish how many have access to research and how many are able to engage in research, so contributing to the evidence base of the profession.

7.9 Recommendations

Several topics evolve for recommendations, addressing issues arising regarding teaching and learning for those entering the profession and currently within in, including introduction of a nationally recognised qualification (NVQ) and a method of benchmarking and evaluating training and development (T.A.P. model), together with issues regarding ongoing development and professionalism, including accessing research opportunities.

H.NOS - awareness

The NOS (including H.NOS), are described by Skills for Health as indicators of best practice, describing what a competent person should do, know and understand. As was evident in the research, around half of the practitioners lacked awareness of the H.NOS, yet these standards are aimed towards influencing their practice. Researchers were similarly lacking in awareness of H.NOS. Both groups predominantly found the launch publicity insufficient, despite having professional membership and engaging in CPD. It is recommended that the H.NOS are publicised more widely, particularly as those practitioners who were aware of the H.NOS tended to have a more positive perception of the H.NOS than those who were unaware of the H.NOS, perhaps indicating they would be favourably received on a wider scale. Furthermore, with hypnosis and hypnotherapy research informing the hypnotherapy sector, it is recommended that the H.NOS are disseminated to research environments and policy makers ensuring that grant/ funding applications and committees and research ethics applications and committees will have an awareness of the implications of the H.NOS. This would bring greater alignment when translating research-driven theory to 'real-world' practice.

Professionalism – Researcher training and research

The transition of research from the laboratory (with its ability to reduce confounding variables) to the 'real world' can be complex. This 'theoretical' or 'conceptual' research, can often then be expected to fit into the reality of the consulting room, with its numerous confounding variables (no two individuals with the same condition will respond in the same way). Adding to the complexity can be differences between practitioners and researchers perceptions of hypnosis and hypnotherapy practice. Such a difference was evident in this research. Hypnosis and hypnotherapy research does inform the hypnotherapy sector and the wider CAM and medical professions, as well as the public. Any misconceptions held by researchers, or limitations due to any narrowness of training, may influence research outcomes. Thus it is recommended that researchers meet a standard of training at least comparable to practitioners, and in accordance with H.NOS. Furthermore, it is advocated that where research is anticipated to have an influence on practice, that the elements of H.NOS are considered at research proposal stage and that ethic applications are considered with 'operator' competence at an appropriate level. It is proposed that professional bodies consider the

recommendations of the White Paper on CAM regulation (House of Lords. Science and Technology Committee, 2000) regarding expanding access to research for practitioners and for research skills training to be included in the syllabus for initial training. This would enable practitioners to gain an understanding of how the research is generated and for researchers to understand the potential influence of their research 'in the field'.

Teaching and learning – validated training

It has been suggested (Mills 1996:48) that professional bodies propose that increased professional training is necessary to provide safe practice for the public. Furthermore, the White Paper on CAM regulation (House of Lords Science and Technology Committee, 2000) indicates a recommendation for validated training. The White Paper also indicates a concept of a basic standard of initial training from which practitioners could then specialise. This concept could be adapted to an externally verified hypnotherapy NVQ which meets the H.NOS and associated Core Curriculum and is required for professional practice whether a medical or lay hypnotherapist, or a researcher. This would offer a clear consistent standard across the profession from which individuals could specialise or focus their training, which would also ensure that the public, the end recipients of any hypnosis and hypnotherapy, receive a recognised standard of care regardless of who the practitioner is.

Teaching, learning and professionalism – the T.A.P. model

As has been discussed in chapter three, the T.A.P. model has applications for hypnotherapy, the therapy professions and indeed the wider arena of training and development. The T.A.P. model enables individuals and organisations to determine training and development needs, screen and compare proposed training, assess initial training and enable identification of areas for development and CPD. Additionally, the model can aid training and staff development managers to consider the appropriate learning outcomes in terms of 'Thoughts' (knowledge, understanding, decision-making) and 'Actions' (skills/ability, communication, behaviour/conduct) and at the appropriate level for the individuals' training and with consideration of development and experience. This may reduce 'wasted' training costs as training and development can be more accurately targeted.

There is a need for a method of assessing and benchmarking training levels, both for those entering the profession and those currently within in and indeed more widely. Whilst it is recognised that such training should initially and fundamentally reflect the H.NOS and Core Curriculum, it has already been discussed that these do not indicate the depth or extent of skills, knowledge and understanding. Furthermore, it can be questioned as to how they relate to the everyday professional practice of a hypnotherapist. It is recommended that a model, such as the T.A.P. model is developed and widely disseminated to enable prospective students, practitioners, researchers, educators and professional bodies to understand the intended influence of any training in terms of the level to which they will be able to perform. Furthermore, this will enable practitioners to be able to identify their present level and any areas where they may wish to develop, thereby promoting reflective practice and CPD.

7.10 Final conclusions

This research analysed the influence of the H.NOS upon hypnosis and hypnotherapy teaching and learning, and professionalism in the UK. It sought the views of four groups within the profession, practitioners and researchers, educators, and professional bodies. It found that there are positive perceptions of influences of the H.NOS on teaching and learning, and on professionalism.

An ever-increasing body of empirical evidence (Lynn and Kirsch, 2006) supports the use of hypnosis and hypnotherapeutic approaches in a wide range of fields. However, hypnotherapy practitioners in the UK are able to practice in any manner they wish, including whether they have formal training (and here the training varies widely), become members of professional bodies (with wide-ranging professional competence and membership standards), commit to voluntary regulation with the CNHC, or follow the standards of H.NOS or its associated core curriculum.

Despite the existence of the H.NOS, the lack of externally verified NVQ's add to the challenge of the public, students, practitioners, educators, professional bodies and healthcare professionals in any attempt to benchmark and understand the present diversity of qualifications. At a time where the public and the NHS are becoming more engaged in hypnotherapy as a CAM, there appears a need for some measure of

standardisation, or at least a minimum standard across all applications of hypnosis and hypnotherapy. Yet the H.NOS and its associated core curriculum, is lacking in detail, particularly in depth and extent of knowledge, understanding and skills.

This project is believed to be the first widespread research of the influence of the H.NOS and the findings, and resulting disseminations, will begin the body of knowledge in this field, together with adding to allied bodies of knowledge. This research can be considered to have raised awareness of the H.NOS by the very nature of circulating requests for participation and by completion of the questionnaires. Concepts of national standards relating to training and to professionalism have been introduced to a wide audience, whether they chose to participate or not. Furthermore, an original contribution, the T.A.P. model, devised specifically for this research, will offer a starting point for the creation of an effective benchmark for training and development.

It is considered that the recommendations for increasing awareness of the H.NOS, more engagement in research, the development of a model for benchmarking training and development and a national qualification for training (such as H.NVQ) would enhance the professionalism of hypnosis and hypnotherapy in the UK, and may ultimately inform the profession worldwide.

To refer back to Isocrates (in Acknowledgements), this research makes clear what is desired to enhance teaching and learning and professionalism in the hypnotherapy sector, with a profession (cities) and standards (laws) and a depth and breadth of knowledge, understanding, skills and expertise (arts), to create an institution (hypnotherapy profession) where all those within it have and use their power of speech.

> *"…there has been implanted in us the power to persuade each other, and to make clear to each other whatever we desire, not only have we escaped the life of wild beasts, but we have come together and founded cities, and made laws, and invented arts; and generally speaking, there is no institution devised by man, which the power of speech has not helped us to establish…."*
>
> Isocrates 'The Antidosis'

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APPENDIX A1

A Simple Guide to Hypnosis Theories

K.Beaven-Marks (2011)

Introduction

This supplement offers a guide to some of the prominent theories over time to the present day. It can be observed that some theories are quite separate, whereas others have common element. Specific theories may be more aligned with the philosophical paradigms of some training organisations and individuals, whereas other organisations and individuals take a more eclectic approach.

Early perspectives - Mesmerism

Early common (mis) connections were with hysteria and demonic possession (Spanos and Chaves, 1991), with links with the supernatural fell out of favour during the The 18th Century Enlightenment period, replaced by animal magnetism, promoted by Venetian Physician Franz Anton Mesmer. He applied his 'therapy' to a range of physiological and psychological conditions, including anxiety, with an approach that involved working with aspects of hysteria and convulsions. The post-convulsion period of stupor, a definitive characteristic, was later called 'Mesmerism', a phrase, in current times, often associated with being 'entranced'. Mesmer can be considered the first scientific researcher of hypnosis (Fromm and Shor, 2007) seeking to explain the forces he worked with. Magnetism fell into disrepute following the 1784 Franklin Commission investigation, which found mesmerism to be the product of the imagination. At that time there was little awareness of the mind-body connection and thus it was concluded the effects to be unreal, although Binet and Féré (1888) wondered why, if medicine of the imagination was most effective, it was not made use of. It is perhaps curious to recognise that a significant aspect of contemporary hypnosis is the utilisation of imagination within the mind-body connection.

Mesmerism continued to be explored through the 19th Century with surgeon James Esdaile, using mesmerism to painlessly perform hundred of major surgeries in India (1902/1989). Esdaile reported that the personality type of his subjects, being simple and

unquestioning (1902/1989) contributed to his success, perhaps an early indicator of a link between personality types and traits and hypnotisability. Esdaile is reported (Robertson, 2009) to have written to James Braid, a British physician, about his techniques although Braid took a different approach in his work, focusing more on a 'nervous sleep' theory. However, Braid is credited with naming 'hypnosis', resulting from an abbreviation of his 'neuro-hypnosis' theory. Later influenced by Charcot (see Dissociation), Braid placed increasing emphasis upon the use of a variety of different verbal and non-verbal forms of suggestion, including the use of "waking suggestion" and self-hypnosis having realised that the approach of the hypnotist significantly influenced the behaviour of those hypnotised, adjusting his theory from neural inhibition to ideo-motor responses (IMR), whereby un-contradicted ideas and thoughts lead to physical responses.

Conditioning and cortical inhibition theories

Ivan Pavlov is commonly associated with 'conditioned response' and the conditioning of hypnotic performance. Windholz (1996) cites Rudolf Heidenhain, a Professor of Physiology at the University of Breslau as likely to have introduced the study of hypnotic phenomena to his student, Ivan Pavlov, looking at it in terms of cortical inhibition as hypnotic phenomena was explored during conditional reflex experiments. A supporting influence perhaps being Ivan Sechenov's (1863/1965) monograph 'Reflexes and the brain', outlining the significance of inhibition and reflex action. A contemporary theorist, Alfred Barios (2001) considers hypnosis inhibits intrusive thoughts and heightens sensitivity to learned associations such as hypnotic suggestions.

Dissociation theories

Hypnosis is considered to be a dissociative state (Kirsch and Lynn, 1998) mediated by neurophysiological influences (Gruzelier, 2006), with dissociation being considered a splitting of awareness.

French neurologist Jean Martin Charcot was an early supporter of a theory of dissociation, further supported by Alfred Binet (1892) and Pierre Janet (1889, 1973)., with three stages to hypnosis: lethargy, induced by eye fixation (looking up at a sport or

moving object to create fatigue of the eye muscles, still a common hypnotic induction technique); catalepsy (muscular rigidity and immobility, often produced in the arm or eyelids); and somnambulism (a deeply dissociated state (Yapko, 2003)). Pierre Janet considered dissociation accounts for much hypnotic phenomena, such as amnesia (1925), although his early views that hypnosis and hysteria are linked is now disputed.

The 'dissociation theory' was developed further by Hilgard, whose later 'neo-dissociation theory' (1977, 1986, 1991, 1994) involves a division of consciousness into two or more components of awareness that are simultaneously occurring, with cognitive division of consciousness beneath the central 'executive ego'. The diminished executive control leads to the subjective perception of non-volition associated with hypnotic responses, perpetuating another misconception that the participant is 'controlled' by the hypnotist. Hilgard uses the metaphor of a hidden observer, which can hear, whilst the hypnotised element follows a suggestion of hypnotic deafness and appears deaf to a particular sound.
Kihlstom (1992, 1998a, 1998b, 2003) associates the neo-dissociation theory with dissociations in explicit and implicit memory in post-hypnotic suggestions and negative hallucinations.

Gruzelier (2006) further considers the dissociative state is facilitated by the thalamocortical attentional network engaging a left frontolimbic attention control system that underpins concentration and sensory fixation, whilst stimulation of the frontolimbic inhibitory systems, through suggestions, triggers a sense of relaxation (Gruzelier, 1998, 2006). Furthermore, right-sided temporo-posterior functions are engaged through suggestions for dreaming and imagery. Bowers (1992) considers a theory of 'dissociated control' concurs with dissociation theories, viewing these processes as dissociating the frontal control of behavioural schemas. This allows for direct activation of suppressed behaviours and thus both emotional processes and behavioural processes are open to influence.

Within neo-dissociation, dissociated control theorists Farvolden and Woody (2004) found high suggestibility individuals had more difficultly with tasks sensitive to frontal lobe function (such as free recall and amnesia) than low suggestibility individuals, yet

there was no difference between high and low individuals for tasks not sensitive to frontal lobe function.

Psychoanalytic, love and fantasy theories

An alternative to the dissociation theory was the Psychoanalytic theory of Sigmund Freud, who was inspired by Charcot's demonstrations of using post-hypnotic suggestions to produce conversion symptoms (Lynn and Kirsch, 2006). Freud considered the submissiveness of patients was like being in love. Modern views, such as Nash (1991) are more broadly associated with imagination and fantasy. Rhue and Lynn (1987, 1989) find that a harsh childhood can develop a strong fantasy ability and this enables individuals to become absorbed more easily in hypnosis. This would appear partially supported by Barrett (1991, 1992, 1996), who found that 'dissociater' highly hypnotisable individuals were those from traumatic pasts, learning to blank out worrying events. However, she also discussed 'fantasisers' highly hypnotisable, reporting these as having matured in environments enabling day-dreaming and imaginary play.

Suggestion theories

A promiment figure in suggestion theory is Hippolyte Bernheim of the Nancy School, one of the two leading neurological enquiry centres in the late 19th century, the other being Jean-Martin Charcot's Salpêtrière School in Paris, both schools finding hypnosis an effective investigative approach.

Fundamentally, a primary aspect of hypnosis can be considered the acceptance of suggestion, and the Suggestion Theory of Hippolyte Bernheim (1884, 1887, 1889, 1900) considered that hypnosis a product of suggestion, being a state of mind induced in one person by another person. This may lead to a misconception that the hypnotist has control of the individual, and conflicts with modern views that all hypnosis is actually self-hypnosis, with the hypnotist acting as a guide. Furthermore, self-hypnosis is an accepted form of hypnosis that includes both suggestions in hypnosis and post-hypnotically (Arons, 1971; Kroger, 1977; Alman and Lambrough, 1992). However, a fundamental aspect of modern hypnosis, including self-hypnosis, is the acceptance of

suggestion and most hypnosis work, from the pre-induction talk, through induction, to therapeutic change, re-alerting and post-hypnotic outcomes involve elements of suggestion.

It could be said that hypnotic suggestion is explicitly intended to make use of the placebo effect. Kirsch characterized hypnosis as a "nondeceptive placebo," that it is a method that openly makes use of suggestion and employs methods to amplify its effects (Kirsch, 1994a, 1994b, 1999).

Bernheim is associated with the refocusing of emphasis from the physical state of hypnosis on to the psychological process of verbal suggestion, considering that *"It is suggestion that rules hypnotism"* (1884, p15). Weitzenhoffer (2000) considers the primacy of verbal suggestion in hypnotism dominate the subject, leading him to suggest Bernheim may be considered the 'father of modern hypnotism'. However, such an accolade may be disputed by Ericksonian followers who tend to consider Milton Erickson to be the father of contemporary hypnosis.

Ericksonian approaches

The 20th Century started with Freud's rejection of hypnosis (Sheehy, 2004), which Lynn and Kirsch (2006) consider may have resulted in its demotion to the fringes of medicine and psychology. One exception was Clark Hull (1933), using hypnosis in experimental studies. It was one of Hull's students, Milton H. Erickson, who was to become perhaps the most significant figure ever in the field of hypnosis, with his unique, ground-breaking and often controversial techniques leading to a branch of hypnosis called 'Ericksonian hypnosis'. This approach is considered to be minimally or non-directive and permissive in nature *("...and I wonder just how soon you will allow your eyes to close..."),* offering the participant at least the perception of choice, although Erickson could, at times, be particularly authoritarian and directive ("*Close your eyes!*"). Erickson was one of the key figures studied by Richard Bandler and John Grinder, the founders of Neuro-linguistic programming (NLP). NLP uses many hypnosis techniques, yet these are often presented as different to the hypnosis state. Perhaps due to this, NLP has gained much popularity in the fields of education and business,

whereas hypnosis has expanded into the research, clinical and therapy fields, as well as sport and entertainment.

Socio-cognitive, role-play and obedience perspectives

Alongside the Ericksonian development of hypnosis, so developed the socio-cognitive perspectives, considering hypnosis a social behaviour with individual's response coming from their expectations, beliefs, experiences, attitudes, knowledge, and imagination (Lynn and Kirsch, 2006) which lead to their understanding of suggestions given. Sarbin (1950) developed this further and considered there to be a role being enacted of a hypnotised subject, with Coe and Sarbin (1991) going further that key influencers are the participants knowledge, imagination and the demands of the situation. Early theories, such as those of Ferenczi (Waxman, 1989) and White (1941) suggested aspects of role play, whether as a child obediently pleasing a parent, or taking, as opposed to playing, the socially constructed role of a hypnotised person (Sarbin, 1950) using a form of learned social behaviour. Although, an initial role-play of hypnosis may develop, with subsequent experiences more likely to be a conditioned response (Pavlov, 1927). Furthermore, Orne (1959) considered social demand responses may be separated by a methodology that determined the 'real' hypnotisable from the 'simulator' hypnotisables.

Scientific perspectives

The most recent theories are developments of early physical and scientific theories. It will be observed that there appears some overlap with the later theories of neo-dissociation. An early perspective on brain functioning can from Ainslie Meares (1960) who considered at the time that hypnosis has an inhibitory effect on the higher centres of the brain, resulting in the participant reverting to an atavistic, primitive state of functioning where the parts of the brain that first evolved dominate. This results in the participant accepting the hypnotist's suggestions without logic or rationality. Another brain related theory is the physical theory (Waxman, 1989; Wyke, 1957, 1960) which considers closing down some sensory functions, such as alertness and attention, governed by the reticular activating system (RAS) makes the participant more susceptible to suggestion. This is facilitated by eye closure, eliminating visual input,

redirecting focus to aural stimuli, particularly the hypnotist's voice, which directs the participant through a process of relaxation that diminishes awareness of the environment and reduces activity of the RAS. More recently, imagining studies, such as functional magnetic resonance imaging (fMRI) and computerised tomography (CT /CAT) facilitate greater understanding of the hypnosis functionality of the brain, including involvement of the rostral anterior cingulate cortex, posterior cerebellum, ventromedial prefrontal cortex, mid-cingulate cortex and hippocampus (Faymonville, *et al.*, 2000; Schulz-Stubner *et al.*, 2004).

Science is further supporting the link between mind and body that is facilitated by hypnosis, with the increasing development in the Psychoneuroimmunology field. For example, there is now greater understanding of the link between psychological processes and immune system functioning, such as with some development of Type 2 diabetes (Kiecolt-Glaser *et al.*, 2002). Furthermore, according to Lutgendorf *et al.* (2003) the influencing of emotions, with hypnosis, offers direct and indirect improvement of immune system functioning.

Integrative therapy

Kirsch and Lynn (2006) consider hypnosis has now evolved into the mainstream of clinical psychology. This is supported by Lynn *et al.* (2000) finding hypnosis beneficial in the effective treatment of a range of medical and psychological conditions together with other studies, including meta-analyses such as that of Kirsch (1990) and Kirsch *et al.* (1995), demonstrating the effectiveness of hypnosis in the enhancement of cognitive-behavioural and psychodynamic therapies.

APPENDIX A2

CNH1

Explore and establish the client's needs for complementary and natural healthcare

OVERVIEW

Practitioners must show their understanding that all forms of complementary and natural healthcare rely on exploring and establishing the client's needs and expectations.

They recognize that this may take place at the outset, but also during the delivery of complementary and natural healthcare.

Identifying this allows the practitioner to consider whether it is appropriate to offer the service to the client, the type of service that should be offered and any required modifications to that service.

Users of this competence will need to ensure that practice reflects up to date information and policies.

PERFORMANCE OUTCOMES

Practitioners must be able to do the following:

1. Evaluate requests for complementary and natural healthcare and take the appropriate action

Explain the nature of the service and fee structures to the client

- Defining the nature of the service provided and fee structures
- Describing the potential risks (relevant to their discipline) of various courses of action for the client

2. Provide an appropriate and safe environment for the service

Understand how to make clients feel welcome and ensure they are as comfortable as possible

- Explaining the concept of health and well-being that is consistent with the practice, principles and theory underlying their discipline.
- Explaining the importance of a suitable environment and making clients feel welcome
- Having knowledge of the anatomy, physiology and pathology relevant to your discipline

3. Discuss the client's needs and expectations, and ask relevant questions

Encourage the client to ask questions, seek advice and express any concerns

- Recognising how the client's previous and present care may affect their health and wellbeing in relation to their discipline
- Illustrating how the psychological and emotional balance, as well as diet and lifestyle of the individual, can affect their health and well being
- Identifying how the context in which people live affects their health and well-being
- Evaluating the conditions for which the discipline is appropriate and those where it must be used with caution
- Understanding the anatomy, physiology and pathology relevant to your discipline

4. Establish the client's needs in a manner which encourages the effective participation of the client and meets their particular requirements

Determine any contra-indications or restrictions that may be present and take the appropriate action.

- Discussing how to establish valid and reliable information about the client, and determine

- the priority of need, in order to plan the service.
- Explaining how to work with clients to determine the appropriate actions.
- Defining the appropriate actions to take to match identified needs
- Understanding the anatomy, physiology and pathology relevant to your discipline

5. Evaluate the information obtained and determine the appropriate action with the client

Complete and maintain records in accordance with professional and legal requirements

- Demonstrating how to select and use different methods for exploring clients' needs
- Explaining how to recognise conditions for which your discipline is unsuitable and for which the client should seek advice from other sources
- Recognising how to judge whether self-care procedure(s) relevant to your discipline are appropriate for the client
- Understanding the anatomy, physiology and pathology relevant to your discipline
- Demonstrating the procedures for record keeping in accordance with legal and professional requirements

APPENDIX A3

CNH2

Develop and agree plans for complementary and natural healthcare with clients

OVERVIEW

Practitioners must recognise how important it is that the planning of complementary and natural healthcare takes place through discussion and agreement with the client and relevant others (e.g.carers).

This competence is about developing and agreeing plans that meet the client's needs. Such plans may be subject to change as the service proceeds.

Users of this competence will need to ensure that practice reflects up to date information and policies

PERFORMANCE OUTCOMES

Practitioners must be able to do the following:

1. Explain the available option(s) which meet the client's identified needs and circumstances

Explain any restrictions, possible responses and advise on realistic expectations

Advise the client when your discipline is inappropriate and help them to consider other options

- Describing the range, purpose and limitations of different methods or approaches which may be used for clients' individual needs
- Explaining how to determine the most appropriate method(s) for different clients and their particular needs

- Discussing how to recognise those occasions when your discipline may complement other healthcare which the client is receiving
- Identifying the alternative options available to clients for whom your discipline is inappropriate

2. Discuss the approach to be taken, the level of commitment required and the potential outcomes and evaluation with the client

Check the client understands and support them to make informed choices

Obtain the client's consent and complete records in accordance with professional and legal requirements

- Defining the role which the client (and others) may take, and may need to take, if the approach is to be successful
- Demonstrating how to support and advise the client to make informed choices
- Exploring how to work with the client and relevant others to plan the approach
- Explaining why evaluation methods should be determined at the planning stage and what the client's role will be in the evaluation
- Describing the importance of encouraging and empowering the client to be as actively involved as possible
- Illustrating the relationship of the client's involvement to the promotion of their health and well-being
- Applying the procedures for record keeping in accordance with legal and professional requirements

APPENDIX A4

Complementary and Natural Healthcare NOS- Principles of Good Practice

These Principles of Good Practice are underpinned by the National Occupational Standards and describe the ways in which practitioners should demonstrate good practice across all of their work.

Practitioners working in complementary and natural healthcare should demonstrate:

1. That they partake in regular and appropriate formal Supervision
2. An understanding of the philosophy and principles underpinning their discipline
3. An understanding of current legislation and policy as it applies to their discipline
4. Respect for clients' dignity, privacy, autonomy, cultural differences and rights
5. Regard for the safety of the client and themselves
6. That they learn from others, including clients and colleagues and continually develop their own knowledge, understanding and skills through reflective practice, and research findings
7. An awareness of their own and others emotional state and responses, incorporating such awareness into their own practice
8. That they communicate clearly, concisely and in a professional manner
9. That they work with confidence, integrity and sensitivity
10. That they undertake systematic, critical evaluation of their professional knowledge
11. That they work within their scope of practice, experience and capability at all times

APPENDIX A5

CNH23

Provide Hypnotherapy to Clients

This standard covers hypnotherapy treatment for individuals. Users of this standard will need to ensure that practice reflects up to date information and policies.

PERFORMANCE OUTCOMES

Practitioners must be able to do the following:

1. Select the methodologies that are appropriate for the client which are consistent with the overall treatment plan.

Discuss with the client the reasons for your choices of methodology at each stage of the treatment.

Explain the possible responses to treatment - in an appropriate manner, level and pace to suit client's understanding

- Explaining the principles of different approaches and their application taking into consideration their method of application and assessment of each individual client.
- Relating the links between case evaluation and selected approaches recognizing the connection between different presenting symptoms and appropriate application of a variety of approaches
- Demonstrating appropriate treatment planning and understand the importance of initial consultation and structure
- Identifying current methodologies, underpinning theories and codes of ethics
- Explaining different methodologies employed in treatment (these may include but are not limited to):
    - the use of formal and informal trance
    - the use of different levels of consciousness
    - the use of direct and indirect approaches
    - the use of direct and indirect suggestions

    - matching different approaches to different clients e.g. permissive or authoritarian
    - the use of mechanistic approaches
    - relationships between different methodologies
- Assessing possible contra-indications for particular presenting issues and understanding issues of safety and appropriateness for each individual client
- Demonstrating the principles of selecting techniques – i.e. matching treatment to client needs
- Recognizing the importance of taking a critical approach in relation to methodologies
- selection

2. Ensure the client is aware of their role in cooperating and participating in the therapy

Discuss the role the client (and companion if relevant) must take for the hypnotherapy treatment to be successful

Encourage them and explain how to:

a) monitor their response to therapy and any self care exercises

b) note any changes in their health and well-being

c) contact the practitioner at an appropriate time if they have any concerns or queries in relation to their treatment

- Identifying the importance of being aware of actions, reactions and interactions of the client by observation and discussion
- Identifying the possible barriers to successful therapy
- Explaining how to safely re-orientate the client at the end of the session

3. Give clear and accurate advice with regard to any relevant aftercare

Support the client to make informed choices.

- Restating the factors to consider when selecting methodology tailored to individual needs

4. Apply the appropriate interventions that are suited to the client's needs

- Relating the links between case evaluation and selected approaches recognizing the connection between different presenting symptoms and appropriate application of a variety of approaches
- Demonstrating appropriate treatment planning and understand the importance of initial consultation and structure
- Identifying current methodologies, underpinning theories and codes of ethics
- Demonstrating the variety of content, structure and approach of different methodologies and the benefits and limitations of each
- Demonstrating the principles of selecting techniques – i.e. matching treatment to client needs
- Restating the factors to consider when selecting methodology tailored to individual needs
- Describing the processes for evaluating information as treatment proceeds and using this to inform future practice

5. Evaluate the outcomes and effectiveness of Hypnotherapy to inform future plans and actions

- Recognizing the importance of building review, reflection and evaluation into treatment planning
- Recognizing the importance of taking a critical approach in relation to methodologies selection

6. Accurately record information and reflect upon the rationale for the treatment programme

- Identifying current methodologies, underpinning theories and codes of ethics
- Explaining the importance of observation of clients throughout the therapeutic process

T.A.P. Level > © K. Beaven-Marks 2010	**One**	**Two**	**Three**	**Four**	**Five**	**Six**	**Seven**
APPENDIX A6	Beginner	Novice	Intermediate	Practitioner	Senior Practitioner	Specialist	Authority
THOUGHTS							
Knowledge	Minimal, unconnected	Direct experience, simple connections	Application beyond direct experience	Proficient body of field knowledge	Enhanced field knowledge	Enhanced knowledge of specialism	Creator of new knowledge
Understanding	Little under-standing of the basic concepts	Some under-standing of the basic concepts	Connections at theoretical level	Extracting specific learning implicit rules	Creating meaning out of new experiences	Relates theory out of professional experiences	Enlightened, abstract conceptualisation
Decision-making	Make decisions with assistance	Breaks problems down	Sense of what is relevant	Adjustment to initial decisions	Identify strategies to changes	Adapt strategies to changes	Simplification and strategies for complexities
ACTIONS							
Skills /Ability	Imitate skills with assistance	Replication with minimal assistance	Gaining refinement with supervision	Able to work unsupervised	The 'knack', expertise, practiced	Highly developed expertise	Expertise and ability to work beyond established protocols
Communication	Basic comm.-unication on key concepts	Personal view on basic concepts	Discuss key concepts	Developing views on topics in field	Establishing views on topics in field	Contributes to field knowledge	Creator of field knowledge
Behaviour / conduct	Need to follow / imitate others	Changes in own behaviour	Behavioural changes to meet perceived role	Credibility	Self – monitoring	Responsibilities/ example to others	High status / high esteem

MAP OF H.NOS to T.A.P. MODEL Appendix A7

H.NOS CNH1 **Explore and establish the client's needs for complementary and natural healthcare**	**THOUGHTS** K = Knowledge U = Understanding D = Decision-making	**ACTIONS** S = Skills / ability C = Communication B = Behaviour / conduct
1. Evaluate requests for complementary and natural healthcare and take the appropriate action		
- Explain the nature of the service and fee structures to the client	K, U	S, C, B
- Define the nature of services provided and fee structures	K, U	S, C, B
- Describe the potential risks (relevant to their discipline) of various sources of action for the client	K, U	S, C, B
2. Provide an appropriate and safe environment for the service		
- Understand how to make clients feel welcome and ensure they are as comfortable as possible	K, U	S, C, B
- Explain the concept of health and well-being that is consistent with the practice, principles and theory underlying their discipline	K, U	S, C, B
- Explain the importance of a suitable environment and making clients feel welcome	K, U	S, C, B
- Have knowledge of the anatomy, physiology and pathology relevant to your discipline	K, U	
3. Discuss the client's needs and expectations, and ask relevant questions		
- Encourage the client to ask questions, seek advice and express any concerns	K, U	S, C, B
- Recognise how the client's previous and present care may affect their health and wellbeing in relation to their discipline	K, U, D	S, C, B
- Illustrate how the psychological and emotional balance, as well as diet and lifestyle of the individual, can affect their health and wellbeing	K, U	S, C, B
- Identify how the context in which people live affects their health and wellbeing	K, U	S, C, B
- Evaluate the conditions for which the discipline is appropriate and those where it must be used with caution	K, U, D	S, C, B
- Understand the anatomy, physiology and pathology relevant to your discipline	K, U	

4. Establish the client's need in a manner which encourages the effective participation of the client and meets their particular requirements		
- Determine any contra-indications or restrictions that may be present and take the appropriate action	K, U, D	S, C, B
- Discuss how to establish valid and reliable information about the client and determine the priority of need, in order to plan the service	K, U, D	S, C, B
- Explain how to work with clients to determine the appropriate actions	K, U, D	S, C, B
- Define the appropriate actions to take to match identified needs	K, U	S, C, B
- Understand the anatomy, physiology and pathology relevant to your discipline	K, U	
5. Evaluate the information obtained and determine the appropriate action with the client: Complete and maintain records in accordance with professional and legal requirements		
- Demonstrate how to select and use different methods for exploring clients' needs	K, U, D	S, C, B
- Explain how to recognise conditions for which your discipline is unsuitable and for which the client should seek advice from other sources	K, U, D	S, C, B
- Recognise how to judge whether self-care procedure(s) relevant to your discipline are appropriate for the client	K, U, D	S, C, B
- Understand the anatomy, physiology and pathology relevant to your discipline	K, U	
- Demonstrate the procedures for record keeping in accordance with legal and professional requirements	K, U	S, B

H.NOS CNH2 **Develop and agree plans for complementary and natural healthcare with clients**	**THOUGHTS**	**ACTIONS**
1. Explain the available option(s) which meet the client's identified needs and circumstances.		
- Explain any restrictions, possible resources, and advice on realistic expectations	K, U, D	S, C, B
- Advise the client when your discipline is inappropriate and help them to consider other options	K, U, D	S, C, B
- Explain how to determine the most appropriate method(s) for different clients and their particular needs	K, U, D	S, C, B
- Discuss how to recognise those occasions where your discipline may complement other healthcare which the client is receiving	K, U, D	S, C, B
- Identify the alternative options available to clients for whom your discipline is inappropriate	K, U, D	S, C, B
2. Discuss the approach to be taken, the level of commitment required and the potential outcomes and evaluation with the client		
- Check the client understands and support them to make informed choices	K, U	S, C, B
- Obtain the client's consent and complete records in accordance with professional and legal requirements	K, U	S, C, B
- Define the role which the client (and others) may take, and may need to take, if the approach is to be successful	K, U	S, C, B
- Demonstrate how to support and advise the client to make informed choices	K, U	S, C, B
- Explore how to work with the client and relevant others to plan the approach	K, U, D	S, C, B
- Explain why evaluation methods should be determined at the planning stage and what the client's role will be in the evaluation	K, U, D	S, C, B
- Describe the importance of encouraging and empowering the client to be as actively involved as possible	K, U	S, C, B
- Illustrate the relationship of the client's involvement to the promotion of their health and wellbeing	K, U	S, C, B
- Apply the procedures for record keeping in accordance with legal and professional requirements	K, U	S, B

H.NOS CNH23 **Provide hypnotherapy to clients**	**THOUGHTS**	**ACTIONS**
1. Select the methodologies that are appropriate for the client which are consistent with the overall treatment plan.		
- Discuss with the clients the reasons for your choices of methodology at each stage of the treatment	K, U, D	S, C, B
- Explain the possible responses to treatment, in an appropriate manner, level and pace to suit client's understanding	K, U, D	S, C, B
- Explain the principles of different approaches and their application, taking into consideration their methods of application and assessment of each individual client	K, U, D	S, C, B
- Relate the links between case evaluation and selected approaches, recognising the connection between presenting symptoms and appropriate application of a variety of approaches	K, U, D	S, C, B
- Demonstrate appropriate treatment planning and understand the importance of initial consultation and structure	K, U	S, C, B
- Identify current methodologies employed in treatment. These may include the use of: formal and informal trance / different levels of consciousness/ direct and indirect approaches / direct and indirect suggestions match different approaches to different clients e.g. permissive or authoritarian / mechanistic approaches / relationships between different methodologies	K, U, D	S, C, B
- Assess possible contra-indications for particular presenting issues and understand issues of safety and appropriateness for each individual client	K, U, D	S, C, B
- Demonstrate the principles of selecting techniques – matching treatment to client needs	K, U, D	S, C, B
- Recognise the importance of taking a critical approach in relation to methodologies	K, U, D	S, C, B
- Selection	K, U, D	S, C, B
2. Ensure the client is aware of their role in co-operating and participating in the therapy		
- Discuss the role the client (and companion if relevant) must take for the hypnotherapy treatment to be successful	K, U	S, C, B
- Encourage them and explain how to monitor their response to therapy and any self-care exercises	K, U	S, C, B
- Encourage them and explain how to note any changes in their health and wellbeing	K, U	S, C, B
- Encourage them and explain how to contact the practitioner at an appropriate time if they have any concerns or queries in relation to their treatment	K, U	S, C, B
- Identify the importance of being aware of actions, reactions and interactions of the client by observation and discussion	K, U	S, C, B
- Identify the possible barriers to successful therapy	K, U	S, C, B
- Explain how to safely re-orientate the client at the end of the session	K, U	S, C, B

3. Give clear and accurate advice with regard to any relevant aftercare. Support the client to make informed choices.		
- Restate the factors to consider when selecting methodology tailored to individual needs	K, U	S, C, B
4. Apply the appropriate interventions that are suited to the client's needs.		
- Relating the links between case evaluation and selected approaches recognising the connection between different presenting symptoms and appropriate application of a variety of approaches	K, U, D	S, C, B
- Demonstrate appropriate treatment planning and understand the importance of initial consultation and structure	K, U, D	S, C, B
- Identify current methodologies, underpinning theories and codes of ethics	K, U	S, B
- Demonstrate the variety of content, structure, and approach of different methodologies and the benefits and limitations of each	K, U, D	S, C, B
- Demonstrate the principles of selecting techniques – matching treatment to client needs	K, U ,D	S, C, B
- Restate the factors to consider when selecting methodology tailored to individual needs	K, U, D	S, C, B
- Describe the processes for evaluating information as treatment proceeds and use this to inform future practice	K, U, D	S, C, B
5. Evaluate the outcomes and effectiveness of hypnotherapy to inform future plans and actions		
- Recognise the importance of building review, reflection and evaluation into treatment planning.	K, U, D	S, C, B
- Recognise the importance of taking a critical approach in relation to methodologies selection	K, U, D	S, C, B
6. Accurately record information and reflect upon the rationale for the treatment programme		
- Identify current methodologies, underpinning theories and codes of ethics	K, U	S, B
- Explain the importance of observation of clients throughout the therapeutic process	K, U	S, C, B

H.NOS Complementary and Natural Healthcare NOS **Principles of Good Practice**	**THOUGHTS**	**ACTIONS**
1. Demonstrate partaking in regular and appropriate formal Supervision	K, U	S,C, B
2. Demonstrate understanding of the philosophy and principles underpinning their discipline	K, U	S,C, B
3. Demonstrate understanding of current legislation and policy as it applies to their discipline	K, U	S,C, B
4. Demonstrate respect for client's dignity, privacy, autonomy, cultural differences and rights	K, U	S,C, B
5. Demonstrate regard for safety of the clients and themselves	K, U, D	S,C, B
6. Demonstrate that they learn from others, including clients and colleague and continually develop their own knowledge, understanding and skills through reflective practice and research findings	K, U, D	S,C, B
7. Demonstrate an awareness of their own and others emotional state and responses, incorporating such awareness into their own practice	K, U, D	S,C, B
8. Demonstrate that they communicate clearly, concisely and in a professional manner	K, U	S,C, B
9. Demonstrate that they work with confident, integrity and sensitivity	K, U	S,C, B
10. Demonstrate that they undertake systematic, critical evaluation of their professional knowledge	K, U, D	S,C, B
11. Demonstrate that they work within their scope of practice, experience and capability at all times	K, U, D	S,C, B

APPENDIX A8

Example of request for participation:

Professional body email letter

I am a Doctorate of Education (Ed.D) student at the University of Greenwich, researching the impact of the Hypnotherapy National Occupational Standards on hypnosis teaching, learning and professionalism in the UK.

This is a large-scale research project, with Research Ethics approval, aiming to capture the opinions of hypnotherapists (including students), hypnotherapy training organisations and schools, professional bodies and researchers who use hypnotherapy.

Your support, in terms of circulating the link to the practitioner and researcher surveys to your members, and the educator questionnaire to your approved training organisations would be most welcome. Furthermore, your completion of the professional body questionnaire would be most valued.

These surveys are not for commercial benefits, the data obtained will be used in my thesis.

I would welcome any opportunity to discuss this research which may be the largest investigation of perceptions of the National Occupational Standards for hypnotherapy and my email address is bk541@:greenwich.ac.uk.

THE SURVEYS:

These links can be copied and pasted into any documents or emails. If you would prefer a web link, then I can generate one and email it to you.

Questionnaire for hypnotherapy practitioners:

https://www.surveymonkey.com/s/PractitionerQuestionnaire2012

Questionnaire for hypnotherapy educators and training organisations:

https://www.surveymonkey.com/s/EducatorQuestionnaire2012

Questionnaire for hypnotherapy professional bodies:

https://www.surveymonkey.com/s/ProfessionalBodyQuestionnaire2012

Questionnaire for researchers using hypnotherapy:

https://www.surveymonkey.com/s/HypnoResearcherQuestionnaire2012

Kind regards,

Kate Beaven-Marks

APPENDIX A9

UNIVERSITY RESEARCH ETHICS COMMITTEE APPLICATION FORM

NOTE FOR APPLICANTS

The University of Greenwich Research Ethics Committee (REC) is responsible for ensuring that any research undertaken by University staff or students, or by other institutions when in collaboration with the university, meets recognised ethical standards. Where ethical issues exist in a research proposal the research should not commence until approval has been obtained from the REC.

Applicants are advised to read the university Research Ethics Policy before completing the form (available online at http://www.gre.ac.uk/policy/rep). In the event of any queries, please consult the secretary to the committee by emailing *research_ethics@gre.ac.uk*. Guidance on risk assessments is available from the university's Safety Unit: email *safetyunit@gre.ac.uk*

For applicants on an M.Phil, Ph.D or thesis component of a professional doctoral programme: Your research proposal must have been approved by the Research Degrees Committee (RDA1) before your application to the University Research Ethics Committee will be considered.

The information collected on this form will be kept as a record of research proposals, and processed within the terms of the Data Protection Act 1998.

ABOUT THE ATTACHED FORM:-

The form should be word processed. It can be obtained from the Research Ethics website or by emailing research_ethics@gre.ac.uk.. Please return one hard copy of the completed form to:

Secretary, University Research Ethics Committee
c/o Vice Chancellor's Office
Queen Anne Court
University of Greenwich
Old Royal Naval College
Park Row
Greenwich, London SE10 9LS

and send an electronic copy by email to research_ethics@gre.ac.uk.

The closing date for receipt of applications is **two weeks** prior to the meeting of the Committee. Dates of committee meetings can be found on the university website at
http://www.gre.ac.uk/offices/academic-council/university-calendar
or by emailing research_ethics@gre.ac.uk

Revised July 2009

RESEARCH ETHICS COMMITTEE APPLICATION CHECKLIST

APPLICATION REFERENCE:
for office use only

Name of Applicant: Kathryn Beaven-Marks	
School: Education	
Title of Research: *An analysis of the impact of the National Occupational Standards for Hypnotherapy on teaching and learning hypnosis and hypnotherapy in the UK.*	
These papers must be attached:	
• Completed application form	Yes
• Copy of consent form	Yes
• Annex I: Participant Information Sheet	Yes
• Risk Assessment Form	Yes
These papers may be required:	**Tick if included:**
• Letters (to participants, parents/guardians, GPs etc)	No
• Questionnaire(s) or indicative questions for interviews	Yes
• Advertisement / Flyer	No
• Annex II - Drugs and Medical Devices	No
• Annex III - Research Involving Human Tissue	No
• Annex IV - Ionising Radiation	No

Has the form been signed? **YES** / NO

Has the risk assessment been signed? **YES** / NO

Have any annexes been signed where necessary? **YES** / NO

SECTION 1: DETAILS OF APPLICANT(S)

Title of Research: *An analysis of the impact of the National Occupational Standards for Hypnotherapy on teaching and learning hypnosis and hypnotherapy in the UK.*

1. Applicant

Surname:	Forename:	Title:
BEAVEN-MARKS	**KATHRYN**	**MISS**
School/Department: EDUCATION		
University address: Not residential Home address: 251 Prospect Road, Woodford Green, Essex IG8 7NQ		
University Tel: N/A	Fax: N/A	E-mail kate7@uel.ac.uk

2. Are you a student? A member of staff? Other?

Student

Programme of Study (if applicable)

MPhil / PhD / **EdD** / Masters by Research / MSc/ MA/ BSc / BA / DipHE / other *(please specify)*

3. Details of any other workers and departments/institutions involved

a. None
b.
c.

4. Project Supervision

Name of Research Supervisor(s) & their contact information

W.D.Goddard, University of Greenwich
020 8331 9561
w.d.goddard@gre.ac.uk

A. Knight, University of Greenwich
020 8223 8954
a.knight@gre.ac.uk

5. Experience

What is your personal experience in the field concerned? *(In the case of student or non-experienced applicants, please state the name and experience of the supervisor, and the degree of supervision).*

The applicant is a trained, qualified and experienced clinical hypnotherapist, Board Certified hypnotist, Certified Instructor and holds several post-graduate qualifications in hypnosis and hypnotherapy. The applicant has lectured on hypnosis, hypnotherapy and hypnosis training in the UK and Internationally, most recently at the NGH World Education Conference in Boston in 2009 and 2010 and the University of East London Learning and Teaching Conference in 2010. During the applicant's studies she has attended a vast number of training organisations as a participant. The applicant is also familiar with the National Occupational Standards in detail. The applicant has conducted research for her MSc. and is experienced in the research methods being employed.

Purpose of the research

What is the primary purpose of the Research?

- Educational qualification **YES**/NO
- Publicly funded trial or scientific investigation YES/**NO**
- Non-externally funded research YES/**NO**
- Commercial Product Development YES/**NO**
- Other externally funded research (Please specify)…… YES/**NO**

YES/**NO**

- Other (Please specify)…….

Please answer the following questions for ALL the investigators involved

6. What are your professional qualifications in the field of study?

Primary Qualifications
General Hypnotherapy Register: General Qualification in Hypnotherapy Practice
Hypnotherapy Training Centre: Diploma in Hypnotherapy
London College of Clinical Hypnosis: Certificate
London College of Clinical Hypnosis: Diploma
London College of Clinical Hypnosis: Practitioner
Mindcare: Diploma in Clinical Hypnotherapy and Psychotherapy
Mindtree: Diploma in Hypnotherapy
National Guild of Hypnotists: Board Certified Hypnotist
UK Academy: Practitioner Neuro-Linguistic Programming (NLP)
UK Academy: Master Practitioner Neuro-Linguistic Programming (NLP)
UK College: Advanced Diploma in Cognitive Behaviour Hypnotherapy

Teaching Qualifications
National Guild of Hypnotists: Certified Instructor

Secondary Qualifications
Academy of Hypnotic Arts: Introduction to Hypnosis
Academy of Hypnotic Arts: Registered Chinosis Coach
City Lit: Working with domestic violence certificate
City Lit: Working with recovered memory certificate
Dominic Beirne School of Clinical Hypnosis and Psychotherapy: EMDR
Institution of Occupational Safety and Health: Introduction to Cognitive Behavioural Therapy
Keytools: Assistive technology and ergonomics workshop attendance certificate
London College of Clinical Hypnosis: Advanced clinical assessment skills
London College of Clinical Hypnosis: Assertiveness training
London College of Clinical Hypnosis: Rapid deep trance hypnosis
Mindcare: Diploma in Complete Mind Therapy
Mindcare: Noesitherapy and hypnotic pain control Rapid results pain consultant
Mindsci: Clinical supervision workshop attendance (Kingston Hospital)
National College of Hypnosis and Psychotherapy conference attendance certificate
NCFE: Level two Certificate in Nutrition and Health
Trinity College: Communication Skills Grade 7
Trinity College: Professional Certificate in Communication Skills
UK Academy: Certified Anxiety Specialist
UK College of Hypnosis and Hypnotherapy: Smoking Cessation Masterclass Certification
Uncommon Knowledge: Precision Hypnosis

Currently studying:
UK Academy: Self-hypnosis workshop specialist certification
Ron Eslinger: Advanced pain management certification
EMDR Institute: EMDR level 2
Trinity College: ATCL Communication Skills

7. Are you a member of any professional, or other, bodies which set ethical standards of behaviour or practice such as the British Psychological Society, Nursing and Midwifery Council, and medical Royal Colleges etc.? If so, please specify.

Professional memberships
British Institute of Hypnotherapy: Member
British Society of Clinical Hypnosis: Full Member
General Hypnotherapy Standards Council: Registered Member
Institute of Leadership and Management: Member
Institute of Risk Management: Member
Institution of Occupational Safety and Health: Chartered Member
International Council of Holistic Therapists: Registered Member
National Guild of Hypnotists: Board Certified Hypnotist
Professional Association of Clinical Therapists: Registered Member
Professional Association of Stage Hypnotists: Member
Royal Society of Medicine: Fellow

Teaching memberships
Association of Therapy Lecturers: Registered Member
Higher Education Academy: Fellow
National Guild of Hypnotists: Certified Hypnotist and Certified Instructor

8. Are you a member of a medical protection organisation? YES / **NO**

Are you a member of any other protection organisation? YES / **NO**

Are you provided with insurance by any professional organisation? YES **/ NO***

*** I have separate insurance to practice and teach hypnosis and hypnotherapy**

(please state which organisation in each case)

SECTION 2: DETAILS OF THE PROJECT

1. What is/are the principal research question(s) posed by this research? **No more than 200 words**

How do the National Occupational Standards (NOS) for Hypnotherapy influence hypnotherapy training programme syllabus in the unregulated hypnosis industry:

1. Are the NOS influential in current training provision?
2. Are the NOS considered the standard for training by professional bodies?
3. Do the NOS have any impact upon qualified hypnosis and hypnotherapy practitioners?
4. Do the NOS have any impact upon researchers who use hypnosis and/or hypnotherapy?
5. Do the NOS have any impact on professionalism within hypnosis and hypnotherapy?

2. Brief outline of the proposed project *(a brief description should be given here in lay terms in no more than 200 words.)*

This project aims to determine what influence the National Occupational Standards (NOS) have had upon hypnosis and hypnotherapy teaching and learning. It will look at four areas within the field: training organisations, professional bodies, practitioners and researchers using hypnosis and/ or hypnotherapy.

The areas to be explored are:

i. The consultation process
ii. The launch process
iii. The impact upon training and learning
iv. The impact upon professional bodies
v. The impact upon competence
vi. The impact upon professionalism
vii. The T.A.P. model ('Thought Action Professionalism model © K Beaven-Marks 2010)
viii. Additional comments the participants may wish to make not addressed by i to vii.

Primarily, the research will be conducted using questionnaires (online), with approximately 10% of participants also being interviewed, either in person or by telephone.

3. What do you consider to be the main ethical issues or problems that may arise with the proposed study? For example:
    - Are there potential adverse effects, risks or hazards for research participants from the interventions?
    - Is there any potential for pain, discomfort, distress, inconvenience or changes in lifestyle for research participants?
    - Is there any potential for adverse effects, risks, hazards, pain, discomfort, distress or inconvenience for the researcher(s) themselves (if any)?

There are no anticipated potential adverse effects, risks or hazards for research participants from the interventions (questionnaires and interviews).

There is no anticipated potential for pain, discomfort, distress, inconvenience or changes in lifestyle for the research participants.

There is no anticipated potential for adverse effects, pain, discomfort, distress or inconvenience for the researcher. Risks and hazards have been assessed (see Risk Assessment) and any residual risk is deemed acceptable. The only significant risk is that of 'lone working' and personal safety during the taking of the interviews. However, this is considered to be of low residual risk due to control measures established which include: check in and check out with colleague by phone prior to and post-interview; only attending business premises; attending during working hours. The researcher is a Chartered Health and Safety Practitioner (Institution of Occupational Safety and Health) with over 18 years experience in education and high risk industry and thus is considered to have sufficient knowledge and experience to makes such judgements.

Participants in this study will be invited to join the study and will do so on their own volition with no adverse consequences. The participants will be informed of the purposes of the study prior to their participation. Survey participants will be informed at the start of the online survey and provided with the information contained in the Participant Information Sheet and the Participant Consent template (annex 1). They will need to indicate (tick the box) on the online survey that they accept this information (and give informed consent) prior to being able move forward through the survey. If they choose not to accept they will be thanked via the survey content and the survey would stop at that point. Interview participants will be provided with a copy of the Participant Information Sheet and the Participant Consent template prior to the commencement of the interview. Participants will clearly be informed that they may choose to withdraw at any time. In addition, all information will remain confidential and the identity of participants will not be revealed. Individual interview participants' names will not be recorded. Given the anticipated sample size it is not expected that any participants could be identified from the data. Although no participant is likely to gain any direct benefit from this study, it is likely that if used it will benefit future course designers and syllabus writers. In conducting this study, any tape recordings or printed data will be secured in locked cupboards with access limited to the researcher only.

The key ethical considerations are those of confidentiality and anonymity. It is considered essential that training providers and those having undergone training feel confident that they may disclose information and views freely and anonymously.

The data will be collected primarily through qualitative questionnaire surveys, complemented with quantitative interviews. The questionnaire will be sent out by using an internet software package called 'Survey Monkey' and this enables replies to be made anonymously. Although participants will have the option of including their contact details, it will be made clear in writing, prior to completing the survey, that their details will not be referred to in the final thesis or in any prepared written material. It will also be made clear to interview participants, again, in writing, prior to commencement of the interview, that their details, will remain anonymous.

4. What steps will be taken to address each of the issues involved?

See above.

5. Is there a potential benefit for research participants?

There are no direct potential benefits for research participants, who will not be paid or receive any other direct rewards. Participants will have the indirect benefit from being able to contribute towards research into a topic which is relevant to the occupation. It could be considered that research participants may benefit from reflection upon the questions raised during the questionnaire and interview and gain greater insight, understanding, awareness or clarification of their views relating to the National Occupational Standards and teaching of hypnosis and hypnotherapy.

6. Will it be necessary for participants to take part in the study without their knowledge and consent at the time (e.g. general public filming/video or recording or covert observation of people)?

No, this will not be necessary. All participation will be with the participant's knowledge and consent.

7. Where will the interaction with participants take place, e.g. online, classroom, public facility, laboratory, office, home, etc?

The questionnaires will be conducted online using email and the 'Survey Monkey' programme.

The interviews will be conducted in hypnotherapy training schools, participants' workplaces or other professional environments (such as meeting rooms or classrooms). There will also be the facilities for interviews conducted over the telephone, or by a series of emails, should this be appropriate and more convenient for the interviewee (for example, when not presently in the UK). No interviews will be conducted in homes, hotels or hazardous environments. Appropriate consideration has been given, in the risk assessment, to 'Lone Working' and good practice will be followed, for example making a phone call to a colleague before entering the premises and an arranged time to call back after the interview.

8. Have any collaborating internal or external Schools or institutions or departments whose resources will be needed, been informed and agreed to participate? YES / NO / **N.A.**
   If so, how have these institutes been informed and how have they given consent (i.e.verbally or written)?

9.
   a. What is the proposed start date of the project? 15th January 2011

   b. What is the proposed end date of the project? 30th March 2012

10. What is the expected total duration of participation in the study for each participant, e.g. 20 minutes to complete a questionnaire, an hour for an interview, etc?

The Questionnaire: 25 minutes (including reading the Participant Information and consenting)
The Interview: 60 minutes (including providing Participant Information and gaining consent)

11. What monitoring arrangements will be in place to check if any new ethical and/or risk issues emerge during the project either with the subject(s) to whom the investigation is directed or with the researchers involved?

Any proposed or potential deviations from the current plan for research will be reviewed for ethical considerations. Furthermore, any such deviations would be discussed with the project supervisors.

12. Are any of the following procedures involved?	
Any invasive procedures, e.g. venepuncture	YES/**NO**
Any intrusive procedures, e.g. questionnaire(s), interview, diary, focus groups	**YES**/NO
Physical contact	YES/**NO**
Any procedure that may cause mental distress, in particular if dealing with vulnerable participants, e.g. young, mentally ill, elderly, etc.	YES/**NO**
Prisoners or others in custodial care	YES/**NO**
Adults with incapacity (physical and/or mental)	YES/**NO**
Children/Young persons (under 18)	YES/**NO**
Drugs, medicinal products or medical devices (if 'yes', complete Annex II)	YES/**NO**
Working with human tissue (if 'yes', complete Annex III)	YES/**NO**
Working with sources of ionising radiation (if 'yes', complete Annex IV)	YES/**NO**

SECTION 3: RECRUITMENT OF PARTICIPANTS/CONSENT

1. How will you approach and recruit participants for the study? Please attach a copy of the advertisement if used. Note: An advertisement will not be used.

Participants will initially be contacted by email:
i. All training organisations initially consulted about the National Occupational Standards
ii. All training organisations recognised by the key hypnotherapy professional bodies
iii. The key hypnotherapy professional bodies
iv. Qualified practitioners of hypnotherapy will be invited, via professional body sites, to complete a questionnaire also.
v. Researchers in UK Universities using hypnosis and / or hypnotherapy

Of those who express a willingness to participate, 10% will be selected at random for interview.

2. How many participants are to take part in this project?

It is expected that 400 training organisations will be contacted, ten professional bodies, ten researchers and up to 500 practitioners of hypnosis and hypnotherapy are anticipated to reply to the invitation.

3. What are the selection criteria?

i. All training organisations initially consulted will be contacted
ii. All training organisations recognised by the key hypnotherapy professional bodies
iii. All key hypnotherapy professional bodies will be contacted
iv. Natural selection (by response) will apply to the invitation for qualified practitioners to complete questionnaires.
v. All known researchers will be contacted

There will be exclusion criteria:

Training organisations contacted in step (i) will not be re-contacted in step (ii) as the same questionnaire will be used.
Only questionnaires which state that they have been completed by a qualified practitioner will be included in the data.

4. If you do not propose to issue a Participant Information Sheet how will prospective participants be informed about their role in the project?

The first page of the online Survey Monkey questionnaire will contain the information that would be issued as a Participant Information Sheet and Participant Consent request

5. Is written consent to be obtained using the REC written consent template? *(see Annex I)* **YES**/NO

   Is a form other than the REC written consent template to be used? YES/**NO**

   Please attach a copy

6. Is parent's/guardian's consent necessary under the guidelines for this research to be carried out? YES/**NO**
   (If YES, in what form - verbal, written, witnessed etc? Please attach a copy of the relevant form. If NO, explain why not.)

NO: The questionnaires and interviews will be conducted with adults and this question does not apply.

7. Will the child's or young person's assent/consent be sought and if so how? YES/**NO**
   (If YES, in what form - verbal, written, witnessed etc? Please attach a copy of the relevant form. If NO, explain why not.)

   No: The questionnaires and interviews will be conducted with adults and this question does not apply.

8. Will payments be made to participants, e.g. reimbursement of expenses, incentives or benefits? *(if YES, please give details)* **NO**

9. What arrangements have been made for participants who might not adequately understand verbal explanations or written information, e.g. where English is not a first language or they have low functional literacy?

All participants will either teach or practice hypnotherapy or hypnosis in English. Therefore it is considered they will have sufficient language skills, both verbal and written to participate effectively. Furthermore, whilst writing in terms appropriate for the intended participant group conversational English is used wherever possible in the 'Participant Information Sheet' for both the questionnaire and the interviews, aiming at a reading level suitable for aged 12 and similar to a broad circulation newspaper. The readability level was checked using the Readability Statistics option in Microsoft Word (2003). The use of an 'active voice' and writing in the first person also aids comprehension and these were included wherever appropriate.

The participant information sheet currently has the following readability statistics:
Passive sentences 0%
Flesch Reading Ease 28.1
Flesch-Kincaid Grade Level 12

Whilst the reading ease rating is reasonable, the grade level is higher than the optimum of 8. However, the grade level is appropriate, as the survey and interview participants are professional individuals and expected to have a reasonable standard of literacy and comprehension.

SECTION 4: INSURANCE/FINANCIAL INTEREST

1. Is the project covered by University of Greenwich Public Liability Insurance *(i.e. it involves healthy participants and is conducted by a University of Greenwich employee or student)?* *** Student of University of Greenwich working with healthy participants.**	**YES** */NO
2. If the project is not covered by University of Greenwich Public Liability insurance, what arrangements have been made to provide liability insurance cover and/or compensation in the event of a claim? **Not Applicable**	
3. Please specify any financial or other direct interest to you or your School arising from this study. **A full declaration** should be included in this space, or on an attached sheet. **Not applicable**	

SECTION 5: RESEARCH GOVERNANCE

1. Does the project need to comply with the requirements of any Department of Health Research Governance Framework? If so, which?	YES **/NO**
2. Does your funding body require you to comply with any other specific Research Governance Framework/Procedure, e.g. ESRC, Standard Research Council conditions for the award of Grants, etc.? * Not applicable	YES **/NO***
3. If "Yes" to either Section 5.1 or 5.2, what arrangements are proposed to ensure compliance? Not applicable	
4. Is personal data to be collected during the research?	**YES**/NO
5. If "Yes" to the previous question, what arrangements will be made to ensure compliance with the Data Protection Act 1998? (e.g. consent from participants; maintaining confidentiality and keeping data securely; information provided to participants in a Participant Information Sheet) Participants will be informed, via the Participant Information Sheet information (online for surveys / paper copy for interviews), that the information collected will be held securely according to the principles of the Data Protection Act 1998. Personal data will be collected during the course of this research solely for the research project for academic research and statistical analysis. This information may be held indefinitely.	

Signatures

I undertake to carry out research in accordance with the University's Research Ethics Policy. In the case of a research degree, I confirm that approval has been given by the Research Degrees Committee. **Signature of applicant**	Date 1st December 2010
I have discussed the project with the applicant, I confirm that all participants are suitably trained and qualified to undertake this research and I approve it. **Signature of Supervisor**	Date
I have discussed the project with the applicant, I confirm that all participants are suitably trained and qualified to undertake this research and I approve it. **Signature of Director of Research or Head of School**	Date

RISK ASSESSMENT FORM

School/Office EDUCATION

Title and description of work Conducting interviews at premises of hypnotherapy training providers.

Location The premises of hypnosis and hypnotherapy training organisations.

Hazards inherent in the Task or Process Include all the significant hazards that are expected or are foreseeable in the context of the work or process that is being undertaken and where it will be done.	**Person(s) at Risk**	**Precautions (Control Measures)** Include precautions for all individuals/groups who may be affected by the hazards you have identified e.g. Staff, students, collaborators, passers by, trainees on courses	**Residual risks** **if all precautions are followed** **High/Medium/Low** If residual risk is judged to be medium or high, further actions must be considered	**Further precautions required**	**Action by whom and when (date)**
Equipment and physical hazards e.g. Tools; machinery; vehicles; manual handling; noise; work at height; electricity; fire; vacuum; high pressure; high temperature; ultra violet; laser; vibration **Only significant hazards need to be recorded**	None				
Chemical hazards e.g. Toxic by inhalation or ingestion; irritant; corrosive; flammable; explosive; oxidising; radioactive Include routes of exposure e.g. skin contact; skin sensitisation; sensitisation by inhalation; toxic by ingestion or inhalation **All work with radioactive materials MUST be approved by the Radiation Protection**	None				

Hazards inherent in the Task or Process Include all the significant hazards that are expected or are foreseeable in the context of the work or process that is being undertaken and where it will be done.	**Person(s) at Risk**	**Precautions (Control Measures)** Include precautions for all individuals/groups who may be affected by the hazards you have identified e.g. Staff, students, collaborators, passers by, trainees on courses	**Residual risks** **if all precautions are followed** **High/Medium/Low** If residual risk is judged to be medium or high, further actions must be considered	**Further precautions required**	**Action by whom and when (date)**
Supervisor					
Personal safety e.g. Physical or verbal attack; disability or health problems; delayed access to personal or medical assistance; failure of routine or emergency communications; security of accommodation and support; getting lost, or stranded by transport; cultural or legal differences	Lone working – researcher	1. Visit premises during normal working hours 2. Do not visit hotels, homes or hazardous locations 3. Check in with a colleague before visit, give visit details and pre-arrange a call back at a defined time. – agreed action protocol in the event of no response retained by colleague and agreed in advance.	LOW	Monitor	KBM to action prior to visits.
Biological agent hazards "any micro-organism, cell culture or human endoparasite including any which have been genetically modified, which may cause infection, allergy, toxicity and other hazards to human health". This includes bacteria, viruses, fungi and parasites Routes of exposure should be included e.g. Blood borne infection; skin contact; skin sensitisation; sensitisation by inhalation; toxic by ingestion or inhalation **Work involving Class 2 agents or above must be approved by the University Biological and Genetic Modification Safety Committee**	None				

Hazards inherent in the Task or Process Include all the significant hazards that are expected or are foreseeable in the context of the work or process that is being undertaken and where it will be done.	**Person(s) at Risk**	**Precautions (Control Measures)** Include precautions for all individuals/groups who may be affected by the hazards you have identified e.g. Staff, students, collaborators, passers by, trainees on courses	**Residual risks** **if all precautions are followed** **High/Medium/Low** If residual risk is judged to be medium or high, further actions must be considered	**Further precautions required**	**Action by whom and when (date)**
before materials are obtained and work commences. **If work involves genetically modified organisms, GMO Risk Assessment form must be completed.**					
Natural physical hazards e.g. Extreme weather; earthquakes and volcanoes; mountains, cliffs and rock falls; glaciers, crevasses and icefalls; caves, mines and quarries; forests including fire; marshes and quicksand; fresh or seawater, tidal surges					
Environmental impact e.g. pollution and waste, deposition of rubbish, disturbance of eco-systems, trampling, harm to animals or plants	None				
Other hazards	None				

Sources of information used for this assessment
(eg manuals and handbooks/suppliers' information/Internet/colleagues)

Applicant is a Chartered safety professional

Person(s) completing this assessment:
(Person carrying out or managing the activity day-to-day)

Name Title Signature _____ 1st December 2010

Kathryn Beaven-Marks Miss

Other persons commenting on the assessment (where required under School/Office arrangements)
(Line manager or Supervisor responsible for the activity, others involved in the decision-making process, others advising on the activity eg Local Safety Officer)

Name Title Signature Date ___/___/___
_____ _____ _____

Person(s) approving this assessment:
(Person with overall responsibility for the activity eg Head of School/Office, Senior Academic or Manager)

Name Title Signature Date ___/___/___
_____ _____ _____

Review of assessment, and revision if necessary
(For continuing work: the assessment must be reviewed for each visit in a series; when there are significant changes to work materials, equipment, methods, location or people involved; and if there are accidents, near misses or complaints associated with the work. If none of these apply, the assessment must be reviewed at least annually)

REVIEW DATE	--/--/----	--/--/----	--/--/----	--/--/----
Name of reviewer				
Signature				
No revisions made				
Changes to activity, hazards, precautions or risks noted in text.				

ANNEX I: PARTICIPANT CONSENT TEMPLATE

This consent form **will** be signed by the actual investigator concerned with the project after having spoken to the participant to explain the project and after having answered his or her questions about the project. Where the survey is online, this will form an online section prior to the main questionnaire survey. Consent will be actively provided i.e. a box ticked to indicate consent. It will be provided in paper format for interview participants.

Title of research*: An analysis of the impact of the National Occupational Standards for Hypnotherapy on teaching and learning hypnosis and hypnotherapy in the UK*

Researcher: Kathryn Beaven-Marks

To be completed by the participant		**Please underline your answer**
1.	I have read the information sheet about this study	YES/NO
2.	I have had an opportunity to ask questions and discuss this study with the researcher	YES/NO
3.	I have received satisfactory answers to all my questions	YES/NO
4.	I have received enough information about this study	YES/NO
5.	I understand that I am free to withdraw from this study: • at any time • without giving a reason for withdrawing • (if I am, or intend to become, a student at the University of Greenwich) without affecting my future with the University	YES/NO
6.	I agree to take part in this study	YES/NO
Signed (Participant)		Date
Name in block letters		
Signature of investigator		Date

This Project is Supervised by:

W.D. Goddard
A. Knight

Contact Details (including telephone number and email address):

w.d.goddard@gre.ac.uk 020 8331 9561
a.knight@gre.ac.uk 020 8331 8954

PARTICIPANT INFORMATION SHEET

Project Title:
An analysis of the impact of the National Occupational Standards for Hypnotherapy on teaching and learning hypnosis and hypnotherapy in the UK.

The Researcher:
Kathryn (Kate) Beaven-Marks
Ed.D. Student at University of Greenwich

The Research
I am exploring the impact of the National Occupational Standards (NOS) for Hypnotherapy to ascertain to what extent they have had an influence on the teaching, learning and professionalism of hypnosis and hypnotherapy in the UK. To gather information for this research, I am seeking the views of hypnotherapy training organisations, professional bodies, practitioners and researchers who use hypnosis or hypnotherapy.

Your participation
I seek your opinion and request that you to complete a brief (15-minute) questionnaire. In addition, I may also invite you to participate in an interview (60 minutes). Your participation is voluntary and you may cease to take part in this study at any time, without penalty. There are no foreseeable risks involved in the participation of this study.

The benefits
I anticipate that the outcomes will indicate the level of influence the NOS have had upon teaching, learning and professionalism of hypnosis and hypnotherapy. I have found little research regarding the impact of the NOS on hypnotherapy, professionalism or complementary medicine. There is also little relating to professionalism and hypnotherapy. I hope that the outcomes will contribute to current knowledge and current literature. I would be delighted to make a summary of the outcomes available to you, should you requested it, when the research is completed.

Data Protection and the Data Protection Act 1998
I will use any personal data that collected during the course of this research project for academic research or statistical analysis. I may hold it indefinitely, and will only make it public in a form that identifies individuals with the consent of the individual. I will hold it securely according to the principles of the Act.

APPENDIX A11

Example of call for participation: Practitioner and researcher email letter

I am a Doctorate of Education (Ed.D) student at the University of Greenwich, researching the impact of the Hypnotherapy National Occupational Standards on hypnosis teaching, learning and professionalism in the UK.

This is a large-scale research project, aiming to capture the opinions of hypnotherapists (including students), hypnotherapy training organisations and schools, professional bodies and researchers who use hypnotherapy. Your support, in terms of completing the practitioner or researcher questionnaire (whichever is most relevant), would be most welcome. Furthermore, it would be greatly appreciated if you would circulate the link to any colleagues or post on relevant forums. These surveys are not for commercial benefits, the data obtained will be used in my thesis.

I would welcome any opportunity to discuss this research which may be the largest investigation of perceptions of the National Occupational Standards for hypnotherapy and would be happy to communicate by email (bk541@greeenwich.ac.uk).

THE SURVEY:
The link can be copied and pasted into any documents or emails. If you would prefer a web link, then I can generate one and email it to you.
Questionnaire for hypnotherapy practitioners:
https://www.surveymonkey.com/s/PractitionerQuestionnaire2012
Questionnaire for researchers using hypnotherapy:
https://www.surveymonkey.com/s/HypnoResearcherQuestionnaire2012

Kind regards,
Kate Beaven-Marks

APPENDIX A12

PARTICIPANT INFORMATION SHEET

Project Title:

An analysis of the impact of the Hypnotherapy National Occupational Standards on hypnosis and hypnotherapy teaching and learning and professionalism in the UK.

The Researcher:

Kathryn (Kate) Beaven-Marks
Ed.D. Student at University of Greenwich

The Research

I am exploring the impact of the National Occupational Standards (NOS) for Hypnotherapy to ascertain to what extent they have had an influence on the teaching, learning and professionalism of hypnosis and hypnotherapy in the UK. To gather information for this research, I am seeking the views of hypnotherapy training organisations, professional bodies, practitioners and researchers who use hypnosis or hypnotherapy.

Your participation

I seek your opinion and request that you to complete a brief (15-minute) questionnaire. In addition, I may also invite you to participate in an interview (60 minutes). Your participation is voluntary and you may cease to take part in this study at any time, without penalty. There are no foreseeable risks involved in the participation of this study.

The benefits

I anticipate that the outcomes will indicate the level of influence the NOS have had upon teaching, learning and professionalism of hypnosis and hypnotherapy. I have found little research regarding the impact of the NOS on hypnotherapy, professionalism or complementary medicine. There is also little relating to professionalism and hypnotherapy. I hope that the outcomes will contribute to current knowledge and current literature. I would be delighted to make a summary of the outcomes available to you, should you requested it, when the research is completed.

Data Protection and the Data Protection Act 1998

I will use any personal data that collected during the course of this research project for academic research or statistical analysis. I may hold it indefinitely, and will only make it public in a form that identifies individuals with the consent of the individual. I will hold it securely according to the principles of the Act.

Practitioner Questionnaire 2012

1. Welcome and participant Info

Welcome to the survey and thank you for participating. Please find detailed below the participant information.

PARTICIPANT INFORMATION

Project title: An analysis of the impact of the National Occupational Standards for hypnotherapy on teaching, learning and professionalism in hypnosis and hypnotherapy in the UK.

THE RESEARCHER
Kathryn (Kate) Beaven-Marks
Ed.D. studuent (Doctorate of Education), University of Greenwich

THE RESEARCH
I am exploring the impact of the National Occupational Standards for hypnotherapy (NOS) to ascertain to what extent they have had an influence on the teaching, learning and professionalism of hypnosis and hypnotherapy in the UK. To gather information for this research, I am seeking the views of practitioners, hypnotherapy training organisations, professional bodies and researchers who use hypnosis or hypnotherapy.

YOUR PARTICIPATION
I seek your opinion and request that you complete this questionnaire. In addition, you may also have an opportunity to participate in an interview, if you wish. Your participation is voluntary and you may cease to take part in this study at any time without penalty. There are no foreseeable risks involved in the participation of this study.

THE BENEFITS
I anticipate that the learning outcomes will indicate the level of influence the NOS have had upon teaching, learning and professionalism of hypnosis and hypnotherapy. There appears to be minimal research regarding the impact of the NOS on hypnotherapy teaching, learning or professionalism, thus I hope that the outcomes will contribute to current knowledge and literature. I would be delighted to make a summary of the outcomes available to you, should you request it, when the research is completed.

DATA PROTECTION AND THE DATA PROTECTION ACT 1998
I will use the data collected during the course of this research project for academic research and statistical analysis purposes. I may hold it indefinitely, and will only make it public in an anonymous form, unless with the explicit permission of the individual. I will hold it securely according to the principles of the Act.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE RESEARCHER
Kate Beaven-Marks
Email: bk541@greenwich.ac.uk
Telephone: 07429 056243

Practitioner Questionnaire 2012

2. Consent

CONSENT FORM

TITLE OF RESEARCH
An analysis of the impact of the National Occupational Standards for hypnotherapy on teaching, learning and professionalism in hypnosis and hypnotherapy in the UK.

SUPERVISION
This project is supervised by W.D. Goddard and A. Knight at the University of Greenwch.

Email: w.d.goddard@gre.ac.uk

Email: a.knight@gre.ac.uk

Tel: 020 8331 8954

CONSENT TO PARTICIPATE
If you have any questions about completing this survey please contact the researcher, using the details on the partipant information sheet.

Please indicate an answer for each question below.

***I have read the participant information about this study**

- ◯ Yes
- ◯ No (if no, please read the participant information)

***I have had an opportunity to ask questions and discuss this study with the researcher (via email/phone)**

- ◯ Yes
- ◯ No

Comments

***I have received satisfactory answers to all my questions**

- ◯ Yes
- ◯ No

***I have received enough information about this study**

- ◯ Yes
- ◯ No

Comments

Practitioner Questionnaire 2012

***I understand that I am free to withdraw from this study at any time, without giving a reason for withdrawing, without penalty and without affecting my future with the University if I am or intend to become a student.**

- ◯ Yes - I understand my right to withdraw
- ◯ No - I do not understand

***I agree to take part in this study**

- ◯ Yes
- ◯ No

Your information

Name	
Age	
Gender	
Ethnic origin	
Contact email	
Contact telephone	
Date of survey completion	
Are you available for a telephone interview (at a convenient time/date)	

Practitioner Questionnaire 2012

3. Awareness

This page seeks information about your awareness of the National Occupational Standards for Hypnotherapy (NOS).

If you know of the NOS for hypnotherapy, how did you find out about them?

- ◯ General media
- ◯ Professional / trade media
- ◯ Professional body
- ◯ Professional peers
- ◯ Consultative body
- ◯ Regulatory body
- ◯ Don't know about the NOS
- ◯ Other

Please specify (if other)

Do you consider the NOS were launched with sufficient publicity?

- ◯ Yes
- ◯ No

Why?

Practitioner Questionnaire 2012

4. Consultation

This page seeks your views about the consultation process of the National Occupational Standards for hypnotherapy (NOS).

When the NOS were at draft stage, were you...?

- ◯ Unaware + would have commented
- ◯ Unaware + would not have commented
- ◯ Aware + no opportunity to comment + would have commented
- ◯ Aware + no opportunity to comment + would not have commented
- ◯ Aware + opportunity to comment + did comment
- ◯ Aware + opportunity to comment + did not comment

Comments

Practitioner Questionnaire 2012

5. Impact on teaching and learning

This page seeks your views on any impact of the National Occupational Standards for hypnotherapy (NOS) on learning and teaching.

To what level have you taken your hypnotherapy training?

- ◯ No formal training
- ◯ Student
- ◯ Basic - entry level
- ◯ Practitioner
- ◯ Advanced
- ◯ Specialist

Comment

Do you participate in Continuous Professional Development (CPD)?

- ◯ Yes
- ◯ No

Did your training meet the NOS? (where applicable)

	Yes	No	Not known	N/A
Initial training	◯	◯	◯	◯
Practitioner training	◯	◯	◯	◯
Advanced training	◯	◯	◯	◯
Specialist training	◯	◯	◯	◯
CPD training	◯	◯	◯	◯

Was it important to you for your training to meet the requirements of the NOS?

	Yes	No	N/A
Initial training	◯	◯	◯
Practitioner training	◯	◯	◯
Advanced training	◯	◯	◯
Specialist training	◯	◯	◯
CPD training	◯	◯	◯

Why?

Practitioner Questionnaire 2012

Do you consider the NOS have been influential in:

	Positive influence	No influence	Negative influence
Hypnotherapy training design and content	◯	◯	◯
Hypnotherapy training provision and how taught	◯	◯	◯
Student learning of hypnotherapy	◯	◯	◯

Why?

Practitioner Questionnaire 2012

6. Impact upon professional bodies

This page seeks your views on any impact of the National Occupational Standards for hypnotherapy (NOS) on your professional body.

Are you accredited or recognised by any hypnosis / hypnotherapy professional bodies?

- ◯ Yes
- ◯ No

Are you aware of any changes your professional body have made to their 'minimum standards' in response to the NOS?

- ◯ Yes
- ◯ No
- ◯ N/A

Have you undertaken further training to meet changes in standards your professional body have made in response to the NOS?

- ◯ Yes
- ◯ No
- ◯ N/A

Has this additional training beneficially added to your training or skill level?

- ◯ Yes
- ◯ No
- ◯ N/A

Practitioner Questionnaire 2012

7. Impact upon competence

This page seeks your views on any impact of the National Occupational Standards for hypnotherapy (NOS) on competence.

How do you consider the NOS reflect professional competence standards in the UK?

- ◯ Minimum - The NOS reflect the minimum professional competence standards
- ◯ General - The NOS reflect the general professional competence standards
- ◯ Maximum - The NOS reflect the maximum professional competence standards

Why?

What level of impact have the NOS had upon competence standards in the UK?

- ◯ Major positive impact
- ◯ Minor positive impact
- ◯ No impact
- ◯ Minor negative impact
- ◯ Major negative impact

Why?

Practitioner Questionnaire 2012

8. Impact upon professionalism

This question page seeks your views on the impact of the National Occupational Standards for hypnotherapy (NOS) on competence. It also asks you to consider the T.A.P. model and where you place yourself and others within that model.

Do you consider the NOS have influenced professionalism within the hypnosis and hypnotherapy sector?

	Positive influence	No influence	Negative influence
The perception of professionalism	◯	◯	◯
The extent of professionalism	◯	◯	◯

Why?

Practitioner Questionnaire 2012

THE T.A.P. MODEL

(c) K. Beaven-Marks 2012

T.A.P. Level >	One	Two	Three	Fo
	Beginner	***Novice***	***Intermediate***	***Pr***
THOUGHTS				
Knowledge	Minimal, unconnected	Direct experience, simple connections	Application beyond direct experience	Pro bo kn
Understanding	Little understanding of the basic concepts	Some understanding of the basic concepts	Connections at theoretical level	Ex sp lea im
Decision-making	Make decisions with assistance	Breaks problems down	Sense of what is relevant	Ad to de
ACTIONS				
Skills /Ability	Imitate skills with assistance	Replication with minimal assistance	Gaining refinement with supervision	Ab un
Communication	Basic communication on key concepts	Personal view on basic concepts	Discuss key concepts	De vie to
Behaviour / conduct	Need to follow / imitate others	Changes in own behaviour	Behavioural changes to meet perceived role	Cr

Practitioner Questionnaire 2012

Please refer to the above model when answering the following questions.

	1	2	3	4	5	6	7
Currently what T.A.P. level do you best meet?	◯	◯	◯	◯	◯	◯	◯
What T.A.P. level do you consider the NOS best reflects?	◯	◯	◯	◯	◯	◯	◯
What T.A.P. level do you consider practitioners should achieve at qualification?	◯	◯	◯	◯	◯	◯	◯

Your comments: Please add any additional views, thoughts or comments relating to the NOS and their impact or otherwise, upon the teaching and learning of hypnosis and hypnotherapy in the UK.

Practitioner Questionnaire 2012

9. Thank you

Thank you for completing this survey. Your time and commitment is greatly appreciated. Please do contact me if you would like further information about the research outcomes.

Kate Beaven-Marks
Email: bk541@greenwich.ac.uk
Phone: 07429 056243

Researchers Questionnaire 2012

1. Welcome and participant Info

Welcome to the survey and thank you for participating. Please find detailed below the participant information.

PARTICIPANT INFORMATION

Project title: An analysis of the impact of the National Occupational Standards for hypnotherapy on teaching, learning and professionalism in hypnosis and hypnotherapy in the UK.

THE RESEARCHER
Kathryn (Kate) Beaven-Marks
Ed.D. studuent (Doctorate of Education), University of Greenwich

THE RESEARCH
I am exploring the impact of the National Occupational Standards for hypnotherapy (NOS) to ascertain to what extent they have had an influence on the teaching, learning and professionalism of hypnosis and hypnotherapy in the UK. To gather information for this research, I am seeking the views of practitioners, hypnotherapy training organisations, professional bodies and researchers who use hypnosis or hypnotherapy.

YOUR PARTICIPATION
I seek your opinion and request that you complete this questionnaire. In addition, you may also have an opportunity to participate in an interview, if you wish. Your participation is voluntary and you may cease to take part in this study at any time without penalty. There are no foreseeable risks involved in the participation of this study.

THE BENEFITS
I anticipate that the learning outcomes will indicate the level of influence the NOS have had upon teaching, learning and professionalism of hypnosis and hypnotherapy. There appears to be minimal research regarding the impact of the NOS on hypnotherapy teaching, learning or professionalism, thus I hope that the outcomes will contribute to current knowledge and literature. I would be delighted to make a summary of the outcomes available to you, should you request it, when the research is completed.

DATA PROTECTION AND THE DATA PROTECTION ACT 1998
I will use the data collected during the course of this research project for academic research and statistical analysis purposes. I may hold it indefinitely, and will only make it public in an anonymous form, unless with the explicit permission of the individual. I will hold it securely according to the principles of the Act.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE RESEARCHER
Kate Beaven-Marks
Email: bk541@greenwich.ac.uk
Telephone: 07429 056243

Researchers Questionnaire 2012

2. Consent

CONSENT FORM

TITLE OF RESEARCH
An analysis of the impact of the National Occupational Standards for hypnotherapy on teaching, learning and professionalism in hypnosis and hypnotherapy in the UK.

SUPERVISION
This project is supervised by W.D. Goddard and A. Knight at the University of Greenwch.

Email: w.d.goddard@gre.ac.uk

Email: a.knight@gre.ac.uk

Tel: 020 8331 8954

CONSENT TO PARTICIPATE
If you have any questions about completing this survey please contact the researcher, using the details on the partipant information sheet.

Please indicate an answer for each question below.

***I have read the participant information about this study**

◯ Yes

◯ No (if no, please read the participant information)

***I have had an opportunity to ask questions and discuss this study with the researcher (via email/phone)**

◯ Yes

◯ No

Comments

***I have received satisfactory answers to all my questions**

◯ Yes

◯ No

***I have received enough information about this study**

◯ Yes

◯ No

Comments

Researchers Questionnaire 2012

***I understand that I am free to withdraw from this study at any time, without giving a reason for withdrawing, without penalty and without affecting my future with the University if I am or intend to become a student.**

- ◯ Yes - I understand my right to withdraw
- ◯ No - I do not understand

***I agree to take part in this study**

- ◯ Yes
- ◯ No

Your information

Name	
Age	
Gender	
Ethnic origin	
Organisation	
Contact email	
Contact telephone	
Date of survey completion	
Are you available for a telephone interview (at a convenient time/date)	

Researchers Questionnaire 2012

3. Awareness

This page seeks information about your awareness of the National Occupational Standards for Hypnotherapy (NOS).

If you know of the NOS for hypnotherapy, how did you find out about them?

- ◯ General media
- ◯ Professional / trade media
- ◯ Professional body
- ◯ Professional peers
- ◯ Consultative body
- ◯ Regulatory body
- ◯ Don't know about the NOS
- ◯ Other

Do you consider the NOS for hypnotherapy were launched with sufficient publicity?

- ◯ Yes
- ◯ No

Why?

Researchers Questionnaire 2012

4. Consultation

This page seeks your views about the consultation process of the National Occupational Standards for hypnotherapy (NOS).

When the NOS were at draft stage, were you...?

- ◯ Unaware + would have commented
- ◯ Unaware + would not have commented
- ◯ Aware + no opportunity to comment + would have commented
- ◯ Aware + no opportunity to comment + would not have commented
- ◯ Aware + opportunity to comment + did comment
- ◯ Aware + opportunity to comment + did not comment

Comments

Researchers Questionnaire 2012

5. Impact on teaching and learning

This page seeks your views on any impact of the National Occupational Standards for hypnotherapy (NOS) on learning and teaching

To what level have you taken your hypnotherapy training?

- ◯ No formal training
- ◯ Student
- ◯ Basic - entry level
- ◯ Practitioner
- ◯ Advanced
- ◯ Specialist

Comment

Do you participate in Continuous Professional Development (CPD)?

- ◯ Yes
- ◯ No

Did your training meet the NOS? (where applicable)

	Yes	No	Not known	N/A
Initial training	◯	◯	◯	◯
Practitioner training	◯	◯	◯	◯
Advanced training	◯	◯	◯	◯
Specialist training	◯	◯	◯	◯
CPD training	◯	◯	◯	◯

Was it important to you for your training to meet the requirements of the NOS?

	Yes	No	N/A
Initial training	◯	◯	◯
Practitioner training	◯	◯	◯
Advanced training	◯	◯	◯
Specialist training	◯	◯	◯
CPD training	◯	◯	◯

Why?

Researchers Questionnaire 2012

Do you consider the NOS have been influential in:

	Positive influence	No influence	Negative influence
Hypnotherapy training design and content	◯	◯	◯
Hypnotherapy training provision and how taught	◯	◯	◯
Student learning of hypnotherapy	◯	◯	◯

Why?

Do you consider the NOS are relevant fo research involving hypnosis and/or hypnotherapy?

	Yes	No
Research involving hypnosis	◯	◯
Research involving hypnotherapy	◯	◯

Researchers Questionnaire 2012

6. Impact upon professional bodies

This page seeks your views on any impact of the National Occupational Standards for hypnotherapy (NOS) on your professional body.

Are you accredited or recognised by any hypnosis / hypnotherapy professional bodies?

- ◯ Yes
- ◯ No

Are you aware of any changes your professional body have made to their 'minimum standards' in response to the NOS?

- ◯ Yes
- ◯ No
- ◯ N/A

Have you taken any additional training to meet changes in standards where your professional body has responded to the NOS?

- ◯ Yes
- ◯ No
- ◯ N/A

Researchers Questionnaire 2012

7. Impact upon competence

This page seeks your views on any impact of the National Occupational Standards for hypnotherapy (NOS) on competence.

How do you consider the NOS reflect professional competence standards in the UK?

- ◯ Minimum - The NOS reflect the minimum professional competence standards
- ◯ General - The NOS reflect the general professional competence standards
- ◯ Maximum - The NOS reflect the maximum professional competence standards

Why?

What level of impact have the NOS had upon competence standards in the UK?

- ◯ Major positive impact
- ◯ Minor positive impact
- ◯ No impact
- ◯ Minor negative impact
- ◯ Major negative impact

Why?

Researchers Questionnaire 2012

8. Impact upon professionalism

This question page seeks your views on the impact of the National Occupational Standards for hypnotherapy (NOS) on competence. It also asks you to consider the T.A.P. model and where you place yourself and others within that model.

Do you consider the NOS have influenced professionalism within the hypnosis and hypnotherapy sector?

	Positive influence	No influence	Negative influence
The perception of professionalism	◯	◯	◯
The extent of professionalism	◯	◯	◯

Why?

Researchers Questionnaire 2012

THE T.A.P. MODEL

(c) K. Beaven-Marks 2012

T.A.P. Level >	One	Two	Three	Fo
	Beginner	***Novice***	***Intermediate***	***Pr***
THOUGHTS				
Knowledge	Minimal, unconnected	Direct experience, simple connections	Application beyond direct experience	Pro bo kn
Understanding	Little understanding of the basic concepts	Some understanding of the basic concepts	Connections at theoretical level	Ex sp lea im
Decision-making	Make decisions with assistance	Breaks problems down	Sense of what is relevant	Ad to de
ACTIONS				
Skills /Ability	Imitate skills with assistance	Replication with minimal assistance	Gaining refinement with supervision	Ab un
Communication	Basic communication on key concepts	Personal view on basic concepts	Discuss key concepts	De vie to
Behaviour / conduct	Need to follow / imitate others	Changes in own behaviour	Behavioural changes to meet perceived role	Cr

Researchers Questionnaire 2012

Please refer to the above model when answering the following questions.

	1	2	3	4	5	6	7
Currently what T.A.P. level do you best meet?	◯	◯	◯	◯	◯	◯	◯
What T.A.P. level do you consider the NOS best reflects?	◯	◯	◯	◯	◯	◯	◯
What T.A.P. level do you consider practitioners should achieve at qualification?	◯	◯	◯	◯	◯	◯	◯
What T.A.P. level do you consider researchers should achieve?	◯	◯	◯	◯	◯	◯	◯

Your comments: Please add any additional views, thoughts or comments relating to the NOS and their impact or otherwise, upon the teaching and learning of hypnosis and hypnotherapy in the UK.

Researchers Questionnaire 2012

9. Thank you

Thank you for completing this survey. Your time and commitment is greatly appreciated. Please do contact me if you would like further information about the research outcomes.

Kate Beaven-Marks
Email: bk541@greenwich.ac.uk
Phone: 07429 056243

Educator and Hypnotherapy Training Organisations Questionnaire 2012

1. Welcome and participant Info

Welcome to the survey & participant information

PARTICIPANT INFORMATION

Project title: An analysis of the impact of the National Occupational Standards for hypnotherapy on teaching, learning and professionalism in hypnosis and hypnotherapy in the UK.

THE RESEARCHER
Kathryn (Kate) Beaven-Marks
Ed.D. studuent (Doctorate of Education), University of Greenwich

THE RESEARCH
I am exploring the impact of the National Occupational Standards for hypnotherapy (NOS) to ascertain to what extent they have had an influence on the teaching, learning and professionalism of hypnosis and hypnotherapy in the UK. To gather information for this research, I am seeking the views of practitioners, hypnotherapy training organisations, professional bodies and researchers who use hypnosis or hypnotherapy.

YOUR PARTICIPATION
I seek your opinion and request that you complete this questionnaire. In addition, you may also have an opportunity to participate in an interview, if you wish. Your participation is voluntary and you may cease to take part in this study at any time without penalty. There are no foreseeable risks involved in the participation of this study.

THE BENEFITS
I anticipate that the learning outcomes will indicate the level of influence the NOS have had upon teaching, learning and professionalism of hypnosis and hypnotherapy. There appears to be minimal research regarding the impact of the NOS on hypnotherapy learning, teaching or professionalism, thus I hope that the outcomes will contribute to current knowledge and literature. I would be delighted to make a summary of the outcomes available to you, should you request it, when the research is completed.

DATA PROTECTION AND THE DATA PROTECTION ACT 1998
I will use the data collected during the course of this research project for academic research and statistical analysis purposes. I may hold it indefinitely, and will only make it public in an anonymous form, unless with the explicit permission of the individual. I will hold it securely according to the principles of the Act.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE RESEARCHER
Kate Beaven-Marks
Email: bk541@greenwich.ac.uk
Telephone: 07429 056243

Educator and Hypnotherapy Training Organisations Questionnaire 2012

2. Consent

CONSENT FORM

TITLE OF RESEARCH
An analysis of the impact of the National Occupational Standards for Hypnotherapy on teaching, learning and professionalism in hypnosis and hypnotherapy in the UK.

SUPERVISION
This project is supervised by W.D. Goddard and A. Knight at the University of Greenwch.

Email: w.d.goddard@gre.ac.uk

Email: a.knight@gre.ac.uk

Tel: 020 8331 8954

CONSENT TO PARTICIPATE
If you have any questions about completing this survey please contact the researcher, using the details on the partipant information sheet.

Please indicate an answer for each question below.

***I have read the participant information about this study**

◯ Yes

◯ No (if no, please read the participant information)

***I have had an opportunity to ask questions and discuss this study with the researcher (via email/phone)**

◯ Yes

◯ No

Comments

***I have received satisfactory answers to all my questions**

◯ Yes

◯ No

Educator and Hypnotherapy Training Organisations Questionnaire 2012

***I have received enough information about this study**

- ◯ Yes
- ◯ No

Comments

***I understand thst I am free to withdraw from this study at any time, without giving a reason for withdrawing, without penalty and without affecting my future with the University if I am or intend to become a student.**

- ◯ Yes - I understand my right to withdraw
- ◯ No - I do not understand

***I agree to take part in this study**

- ◯ Yes
- ◯ No

Your information

Name	
Age	
Gender	
Ethnic origin	
Organisation name	
Contact email	
Contact telephone	
Date of survey completion	
Are you available for a telephone interview (at a convenient time/date)	

Educator and Hypnotherapy Training Organisations Questionnaire 2012

3. Awareness

This page seeks information about your awareness of the National Occupational Standards (NOS) for hypnotherapy.

How did your organisation find out about the NOS (if they did know)?

- ◯ General media
- ◯ Professional / trade media
- ◯ Professional body
- ◯ Professional peers
- ◯ Consultative body
- ◯ Regulatory body
- ◯ Not aware of the NOS
- ◯ Other

Please specify (if other)

Does your organisation consider the NOS were launched with sufficient publicity to reach all involved parties?

- ◯ Yes
- ◯ No

Why?

Educator and Hypnotherapy Training Organisations Questionnaire 2012

4. Consultation

This page seeks your views about the consultation process of the National Occupational Standards (NOS).

Did your organisation have the opportunity to comment on the draft NOS?

- ◯ YES: Had the opportunity to and did comment
- ◯ NO: Had the opportunity to and did not comment
- ◯ NO: Did not have the opportunity but would have commented
- ◯ NO: Did not have the opportunity but would not have commented

Why?

Educator and Hypnotherapy Training Organisations Questionnaire 2012

5. Impact on teaching and learning

This page seeks your views on any impact of the National Occupational Standards (NOS) on learning and teaching.

Does your training organisation use the NOS as criteria for any of the following?

	Yes	No
Entry level training	◯	◯
Practitioner level training	◯	◯
Advanced level training	◯	◯
Specialist topic training	◯	◯
CPD (continuous professional development) workshops, seminars or update training	◯	◯

Why?

Is it important for training organisations to meet the NOS for?

	YES (my organisation)	YES (all organisations)	NO
Initial training	◯	◯	◯
Practitioner level training	◯	◯	◯
Post-qualification advanced training	◯	◯	◯
Post-qualification specialist training	◯	◯	◯
Continuous professional development training	◯	◯	◯

Why?

Does your organisation consider the NOS have been influential in:

	Positive influence	No influence	Negative influence
Training design / content in your organisation	◯	◯	◯
Training design / content in organisations generally	◯	◯	◯
Training provision / how taught in your organisation	◯	◯	◯
Training provision / how taught in organisations generally	◯	◯	◯
Student learning in your organisation	◯	◯	◯
Student learning in organisations geneally	◯	◯	◯

Why?

Educator and Hypnotherapy Training Organisations Questionnaire 2012

Educator and Hypnotherapy Training Organisations Questionnaire 2012

6. Impact upon professional bodies

This page seeks your views on any impact of the National Occupational Standards (NOS) on your professional body.

Is your organisation accredited or recognised by any hypnosis / hypnotherapy professional bodies?

- ◯ Yes
- ◯ No

Why?

Is your organisation accredited or recognised by any other professional organisations?

- ◯ Yes
- ◯ No

Why?

Is your organisation aware of any changes these bodies or organisations have made to their 'minimum standards' in response to the NOS?

- ◯ Yes
- ◯ No

Why?

Has your organisation amended their training syllabus to accommodate 'minimum standards' other bodies or organisations have made in response to the NOS?

- ◯ YES: Aware of changes to minimum standards and amended syllabus
- ◯ NO: Aware of changes to minimum standards and did not amend syllabus
- ◯ NO: Not aware of changes to minimum standards

Why?

Educator and Hypnotherapy Training Organisations Questionnaire 2012

If your organisation has made changes in response to revised 'mimimum standards' do you feel this has added to your training?

- ◯ Yes
- ◯ No
- ◯ N/A

Why?

Educator and Hypnotherapy Training Organisations Questionnaire 2012

7. Impact upon competence

This page seeks your views on any impact of the National Occupational Standards (NOS) on competence.

How does your organisation consider the NOS reflect professional competence standards in the UK?

- ◯ Minimum: NOS reflect the minimum professional competence standards
- ◯ General: NOS reflect the general professional competence standards
- ◯ Maximum: NOS reflect the maximum professional competence standards

Why?

How does your organisation consider the NOS reflect the professional competence standards required by your professional body?

- ◯ Higher: The NOS reflect a higher standard than the professional body
- ◯ Same: The NOS reflect the same standard as the professional body
- ◯ Lower: The NOS reflect a lower standard than the professional body

Why?

What level of impact does your organisation consider the NOS have had upon competence standards in the UK?

- ◯ Major positive impact
- ◯ Minor positive impact
- ◯ No impact
- ◯ Minor negative impact
- ◯ Major negative impact

Why?

Educator and Hypnotherapy Training Organisations Questionnaire 2012

8. Impact upon professionalism

This question page seeks your views on the impact of the National Occupational Standards (NOS) on professionalism. It also asks you to consider the T.A.P. model and where you place your organisation and others within that model.

How does your organisation consider the NOS have influenced professionalism within the hypnosis and hypnotherapy sector?

	Positive influence	No influence	Negative influence
Perception of professionalism	◯	◯	◯
Extent of professionalism	◯	◯	◯

Why?

THE T.A.P. MODEL

(c) K.Beaven-Marks 2012

T.A.P. Level >	One	Two	Three	Fo
	Beginner	*Novice*	*Intermediate*	*Pr*
THOUGHTS				
Knowledge	Minimal, unconnected	Direct experience, simple connections	Application beyond direct experience	Pro bo kn
Understanding	Little understanding of the basic concepts	Some understanding of the basic concepts	Connections at theoretical level	Ex sp lea im
Decision-making	Make decisions with assistance	Breaks problems down	Sense of what is relevant	Ad to de
ACTIONS				
Skills /Ability	Imitate skills with assistance	Replication with minimal assistance	Gaining refinement with supervision	Ab un
Communication	Basic communication on key concepts	Personal view on basic concepts	Discuss key concepts	De vie to
Behaviour / conduct	Need to follow / imitate others	Changes in own behaviour	Behavioural changes to meet perceived role	Cr

Educator and Hypnotherapy Training Organisations Questionnaire 2012

Please refer to the above model when answering the following questions.

	1	2	3	4	5	6	7
What level does your practitioner training best meet?	◯	◯	◯	◯	◯	◯	◯
What level do the NOS best meet?	◯	◯	◯	◯	◯	◯	◯
What level do you consider practitioners should achieve at qualification?	◯	◯	◯	◯	◯	◯	◯

Why?

Your comments: Please add any additional views, thoughts or comments relating to the NOS and their impact or otherwise, upon the teaching and learning of hypnosis and hypnotherapy in the UK.

Educator and Hypnotherapy Training Organisations Questionnaire 2012

9. Thank you

Thank you for completing this survey. Your time and commitment is greatly appreciated. Please do contact me if you would like further information about the research outcomes.

Kate Beaven-Marks
Email: bk541@greenwich.ac.uk
Phone: 07429 056243

Hypnotherapy Professional Bodies Questionnaire 2012

1. Welcome and participant Info

Welcome to the survey & participant information

PARTICIPANT INFORMATION

Project title: An analysis of the impact of the National Occupational Standards for hypnotherapy on teaching, learning and professionalism in hypnosis and hypnotherapy in the UK.

THE RESEARCHER
Kathryn (Kate) Beaven-Marks
Ed.D. studuent (Doctorate of Education), University of Greenwich

THE RESEARCH
I am exploring the impact of the National Occupational Standards for hypnotherapy (NOS) to ascertain to what extent they have had an influence on the teaching, learning and professionalism in hypnosis and hypnotherapy in the UK. To gather information for this research. I am seeking the views of practitioners, hypnotherapy training organisations, professional bodies and researchers who use hypnosis or hypnotherapy.

YOUR PARTICIPATION
I seek your opinion and request that you complete this questionnaire. In addition, you may also have an opportunity to participate in an interview, if you wish. Your participation is voluntary and you may cease to take part in this study at any time without penalty. There are no foreseeable risks involved in the participation of this study.

THE BENEFITS
I anticipate that the learning outcomes will indicate the level of influence the NOS have had upon teaching, learning and professionalism in hypnosis and hypnotherapy. There appears to be minimal research regarding the impact of the NOS on hypnotherapy, learning or professionalism, thus I hope that the outcomes will contribute to current knowledge and literature. I would be delighted to make a summary of the outcomes available to you, should you request it, when the research is completed.

DATA PROTECTION AND THE DATA PROTECTION ACT 1998
I will use the data collected during the course of this research project for academic research and statistical analysis purposes. I may hold it indefinitely, and will only make it public in an anonymous form, unless with the explicit permission of the individual. I will hold it securely according to the principles of the Act.

IF YOU HAVE QUESTIONS PLEASE CONTACT THE RESEARCHER
Kate Beaven-Marks
Email: bk541@greenwich.ac.uk
Telephone: 07429 056243

Hypnotherapy Professional Bodies Questionnaire 2012

2. Consent

CONSENT FORM

TITLE OF RESEARCH
An analysis of the impact of the National Occupational Standards for hypnotherapy on teaching, learning and professionalism in hypnosis and hypnotherapy in the UK.

SUPERVISION
This project is supervised by W.D. Goddard and A. Knight at the University of Greenwch.

Email: w.d.goddard@gre.ac.uk

Email: a.knight@gre.ac.uk

Tel: 020 8331 8954

CONSENT TO PARTICIPATE
If you have any questions about completing this survey please contact the researcher, using the details on the partipant information sheet.

Please indicate an answer for each question below.

***I have read the participant information about this study**

- ◯ Yes
- ◯ No (if no, please read the participant information)

***I have had an opportunity to ask questions and discuss this study with the researcher (via email/phone)**

- ◯ Yes
- ◯ No

Comments

***I have received satisfactory answers to all my questions**

- ◯ Yes
- ◯ No

Hypnotherapy Professional Bodies Questionnaire 2012

***I have received enough information about this study**

- ◯ Yes
- ◯ No

Comments

***I understand thst I am free to withdraw from this study at any time, without giving a reason for withdrawing, without penalty and without affecting my future with the University if I am or intend to become a student.**

- ◯ Yes - I understand my right to withdraw
- ◯ No - I do not understand

***I agree to take part in this study**

- ◯ Yes
- ◯ No

Your information

Name	
Age	
Gender	
Ethnic origin	
Organisation name	
Contact email	
Contact telephone	
Date of survey completion	
Are you available for a telephone interview (at a convenient time/date)	

Hypnotherapy Professional Bodies Questionnaire 2012

3. Awareness

This page seeks information about your awareness of the National Occupational Standards for hypnotherapy (NOS).

How did your organisation find out about the NOS (if they did know)?

- ◯ General media
- ◯ Professional / trade media
- ◯ Professional body
- ◯ Professional peers
- ◯ Consultative body
- ◯ Regulatory body
- ◯ Not aware of the NOS
- ◯ Other

Please specify (if other)

Does your organisation consider the NOS were launched with sufficient publicity to reach all involved parties?

- ◯ Yes
- ◯ No

Why?

Hypnotherapy Professional Bodies Questionnaire 2012

4. Consultation

This page seeks your views about the consultation process of the National Occupational Standards for hypnotherapy (NOS).

Did your organisation have the opportunity to comment on the draft NOS?

- ◯ YES: Had the opportunity to and did comment
- ◯ NO: Had the opportunity to and did not comment
- ◯ NO: Did not have the opportunity but would have commented
- ◯ NO: Did not have the opportunity but would not have commented

Why?

Hypnotherapy Professional Bodies Questionnaire 2012

5. Impact on teaching and learning

This page seeks your views on any impact of the National Occupational Standards for hypnotherapy (NOS) on learning and teaching.

When the NOS were launched, did your organisation change any existing standards for:

	Yes	No
Entry level training	◯	◯
Practitioner level training	◯	◯
Advanced level training	◯	◯
Specialist topic training	◯	◯
CPD (continuous professional development) workshops, seminars or update training	◯	◯

Why?

Does your organisation presently use the NOS as criteria for standards for any of the following?

	YES: meets NOS	YES: exceeds NOS	No
Entry level training	◯	◯	◯
Practitioner level training	◯	◯	◯
Advanced level training	◯	◯	◯
Specialist topic training	◯	◯	◯
CPD (continuous professional development) workshops, seminars or update training	◯	◯	◯

Why?

Hypnotherapy Professional Bodies Questionnaire 2012

Does your organisation consider it important for all professional bodies to use the NOS as criteria for standards for any of the following?

	Yes	No
Entry level training	◯	◯
Practitioner level training	◯	◯
Advanced level training	◯	◯
Specialist topic training	◯	◯
CPD (continuous professional development) workshops, seminars or update training	◯	◯

Why?

Does your organisation consider it important for training organisations to meet the NOS for?

	YES	NO
Initial training	◯	◯
Practitioner level training	◯	◯
Post-qualification advanced training	◯	◯
Post-qualification specialist training	◯	◯
Continuous professional development training	◯	◯

Why?

Does your organisation consider the NOS have been influential in:

	Positive influence	No influence	Negative influence
Training design / content	◯	◯	◯
Training provision / how taught	◯	◯	◯
Student learning in organisations	◯	◯	◯

Why?

Hypnotherapy Professional Bodies Questionnaire 2012

6. Impact upon professional bodies

This page seeks your views on any impact of the National Occupational Standards for hypnotherapy (NOS) upon your organisation.

Is your organisation accredited or recognised by any hypnosis / hypnotherapy regulatory body?

- ◯ Yes
- ◯ No

Why?

How does your organisation consider the NOS relate to the mimimum professional competence standards for membership as required by your organisation?

- ◯ NOS are a lower standard than your organisation's minimum requirements
- ◯ NOS are a higher standard than your organisation's minimum requirements

Comments:

Has your organisation reviewed or revised any professional competence standards for membership in response to the NOS?

- ◯ YES: Increased to meet NOS
- ◯ YES: Decreased to meet NOS
- ◯ NO change as sufficient to meet NOS already
- ◯ NO change as do not wish to meet NOS

Why?

Has your organisation amended their training syllabus or guidelines to training schools to accommodate the NOS?

- ◯ YES
- ◯ NO:

Why?

Hypnotherapy Professional Bodies Questionnaire 2012

7. Impact upon competence

This page seeks your views on any impact of the National Occupational Standards for hypnotherapy (NOS) on competence.

How does your organisation consider the NOS represent professional competence standards in the UK?

- ◯ Minimum - The NOS reflect the minimum professional competence standards
- ◯ General - The NOS reflect the general professional competence standards
- ◯ Maximum - The NOS reflect the maximum professional competence standards

Why?

How does your organisation consider the NOS reflect the professional competence standards required by your organisation?

- ◯ Higher - The NOS reflect a higher standard than your organisation
- ◯ Same - The NOS reflect a similar or the same standard as your organisation
- ◯ Lower - The NOS reflect a lower standard than your organisation

What level of impact does your organisation consider the NOS have had upon competence standards in the UK?

- ◯ Major positive impact
- ◯ Minor positive impact
- ◯ No impact
- ◯ Minor negative impact
- ◯ Major negative impact

Why?

Hypnotherapy Professional Bodies Questionnaire 2012

8. Impact upon professionalism

This question page seeks your views on the impact of the National Occupational Standards for hypnotherapy (NOS) on professionalism. It also asks you to consider the T.A.P. model and where you place your organisation and others within that model.

Does your organisation consider the NOS have influenced the perception of professionalism within the hypnosis and hypnotherapy sector?

	Positive influence	No influence	Negative influence
The perception of professionalism	◯	◯	◯
The extent of professionalism	◯	◯	◯

Why?

Hypnotherapy Professional Bodies Questionnaire 2012

THE T.A.P. MODEL

(c) K.Beaven-Marks 2012

T.A.P. Level >	One	Two	Three	Fo
	Beginner	***Novice***	***Intermediate***	***Pr***
THOUGHTS				
Knowledge	Minimal, unconnected	Direct experience, simple connections	Application beyond direct experience	Pro bo kn
Understanding	Little understanding of the basic concepts	Some understanding of the basic concepts	Connections at theoretical level	Ex sp lea im
Decision-making	Make decisions with assistance	Breaks problems down	Sense of what is relevant	Ad to de
ACTIONS				
Skills /Ability	Imitate skills with assistance	Replication with minimal assistance	Gaining refinement with supervision	Ab un
Communication	Basic communication on key concepts	Personal view on basic concepts	Discuss key concepts	De vie to
Behaviour / conduct	Need to follow / imitate others	Changes in own behaviour	Behavioural changes to meet perceived role	Cr

Hypnotherapy Professional Bodies Questionnaire 2012

Please refer to the above model when answering the following questions.

	1	2	3	4	5	6	7
What level do your practitioner training requirements best meet?	◯	◯	◯	◯	◯	◯	◯
What level do the NOS best meet?	◯	◯	◯	◯	◯	◯	◯
What level do you consider practitioners should achieve at qualification?	◯	◯	◯	◯	◯	◯	◯

Why?

Your comments: Please add any additional views, thoughts or comments relating to the NOS and their impact or otherwise, upon the teaching and learning of hypnosis and hypnotherapy in the UK.

Hypnotherapy Professional Bodies Questionnaire 2012

9. Thank you

Thank you for completing this survey. Your time and commitment is greatly appreciated. Please do contact me if you would like further information about the research outcomes.

Kate Beaven-Marks
Email: bk541@greenwich.ac.uk
Phone: 07429 056243