MEASURING THE CORE COMPETENCIES OF ERICKSONIAN HYPNOSIS

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"Materials or conversations connected with this course may include interventions and modalities that are beyond the authorized practice of mental health professionals. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice in accordance with and in compliance with your professional standards."

MEASURING THE CORE COMPETENCIES OF ERICKSONIAN HYPNOSIS

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THE RESEARCH QUESTION

Is there really such a thing as Ericksonian therapy?

Is it possible for a therapy to have any coherency (or guiding principles shared by its teachers and students) when it prides itself on operating independent of a theoretical model, and is allegedly so steeped in creativity that every therapist learns to conduct treatment in a way that fits his or her own unique personality, while at the same time inventing new techniques for different client needs.

Is something special being taught? Are there a set of core competencies that can be observed and measured amongst those who claim to practice Ericksonian therapy?

Workshop Survey Who here has training in Ericksonian therapy? Do you feel that you acquired a special/unique skill set?

WHY THE QUESTION NEEDS TO BE ASKED

Research The long-term goal is to support ongoing research into therapy outcomes using randomized clinical trials (RCT). For this to occur, researchers must be able to identify when Ericksonian therapy is occurring versus some other form of therapy.

Deliberate Practice *"If I wish to measure my progress, in order to increase my skills as an Ericksonian therapist, then what do I measure?"* (Chow, et al., 2015)

Understanding Most therapies revolve around a small number of techniques, which are sequentially organized in a standardized protocol, are derived from a singular concept that offers a conclusive statement on what constitutes mental well-being, and these elements are then codified in a treatment manual. Any therapy that lacks these basic elements must conceptually defend its complexity (Boutron, 2008).

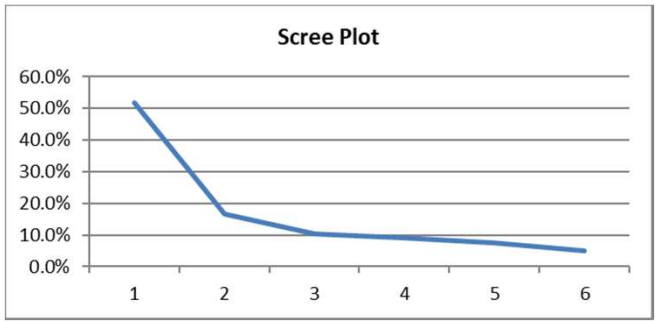
THE METHOD

Phase 1 Survey data from 30 experts (7 countries) who are collectively responsible for the largest portion of the literature and training in Ericksonian institutes/congresses.

Different versions of a sum scales measurement device were tested, eliminating low reliability items. The most robust items were chosen to represent 6 different factors.

Phase 2 Testing psychometric properties. Unidimensionality tested using Exploratory Factor Analysis (EFA), extraction method used for the EFA was Principal Axis Factoring (PAF).

The first factor accounted for 51.8% of the variance, after which it dropped to 16.5% and leveled off, thus the 6 factors appear to be unidimensional.

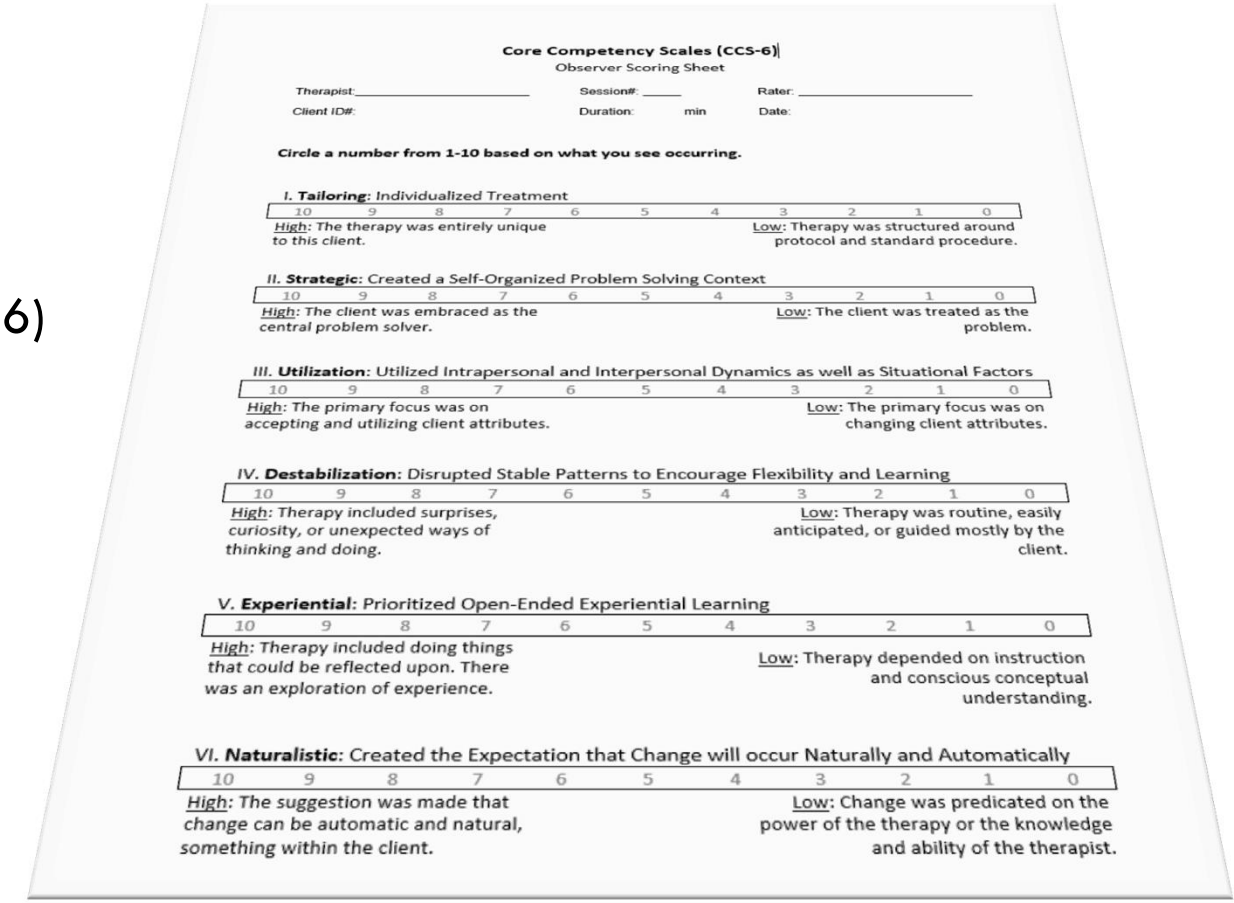


THE DEVICE

The Core Competencies Scale (CCS-6) is a sum scales measurement device

Score ranges from 0-60

Six factors



Core Competency Scales (CCS-6)
Observer Scoring Sheet

Therapist:_____ Session#: _____ Rater: _____
Client ID#: Duration: min Date:

Circle a number from 1-10 based on what you see occurring.

I. ***Tailoring****:* Individualized Treatment
10 9 8 7 6 5 4 3 2 1 0
High: The therapy was entirely unique to this client. Low: Therapy was structured around protocol and standard procedure.

II. ***Strategic****:* Created a Self-Organized Problem Solving Context
10 9 8 7 6 5 4 3 2 1 0
High: The client was embraced as the central problem solver. Low: The client was treated as the problem.

III. ***Utilization****:* Utilized Intrapersonal and Interpersonal Dynamics as well as Situational Factors
10 9 8 7 6 5 4 3 2 1 0
High: The primary focus was on accepting and utilizing client attributes. Low: The primary focus was on changing client attributes.

IV. ***Destabilization****:* Disrupted Stable Patterns to Encourage Flexibility and Learning
10 9 8 7 6 5 4 3 2 1 0
High: Therapy included surprises, curiosity, or unexpected ways of thinking and doing. Low: Therapy was routine, easily anticipated, or guided mostly by the client.

V. ***Experiential****:* Prioritized Open-Ended Experiential Learning
10 9 8 7 6 5 4 3 2 1 0
High: Therapy included doing things that could be reflected upon. There was an exploration of experience. Low: Therapy depended on instruction and conscious conceptual understanding.

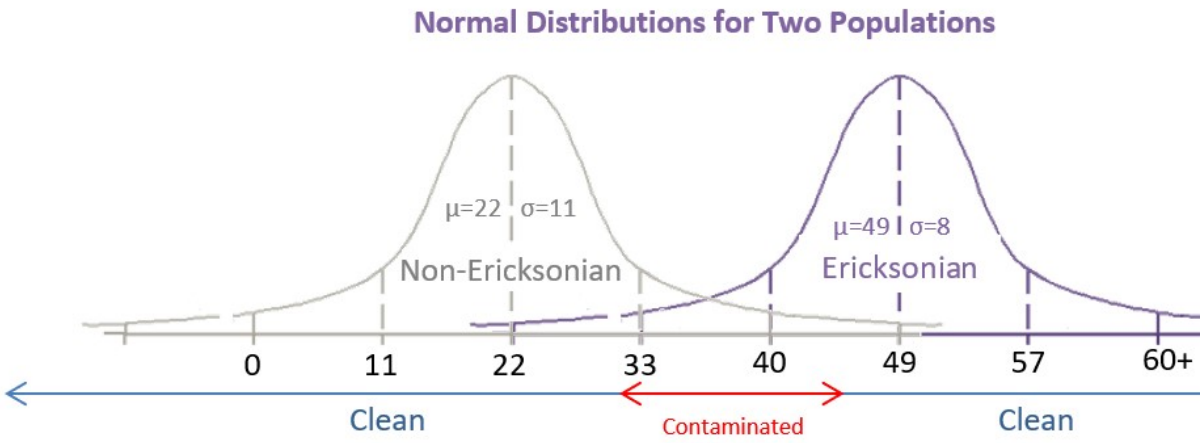
VI. ***Naturalistic****:* Created the Expectation that Change will occur Naturally and Automatically
10 9 8 7 6 5 4 3 2 1 0
High: The suggestion was made that change can be automatic and natural, something within the client. Low: Change was predicated on the power of the therapy or the knowledge and ability of the therapist.

RELIABILITY & VALIDITY

Reliability indices Cronbach's coefficient alpha $\alpha = (k/(k-1)) * [1 - \Sigma(s^2_i)/s^2_{sum}]$, resulting in relatively high covariance between subjects ($\alpha = .76$), and split-half ($r = .61$)

Discriminant validity Compared scale scores obtained from ratings of established experts in Ericksonian therapy versus ratings of known experts in other fields. There was a significant effect for therapy approach, $t(65)=5.01$, $p<.0001$, with Ericksonians receiving significantly higher scores than Non-Ericksonians.

Ericksonian (M=49, SD=8, n=83)
Other (M=22, SD=11, n=49)
To obtain clean scores, it is necessary to go no further than 1 standard deviation from the mean for either population (68% CI).

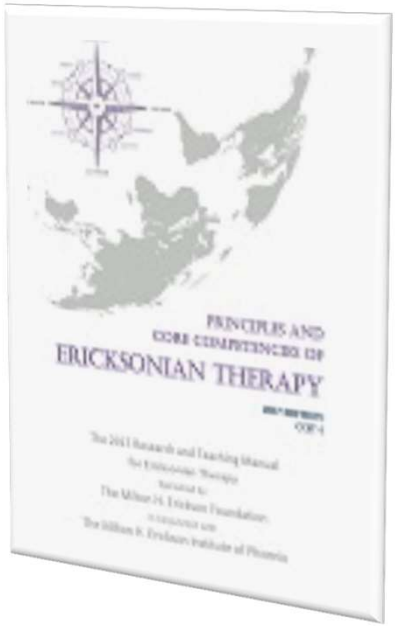


THE TREATMENT MANUAL

Phase 3 All of the original experts that were surveyed were asked to examine the treatment manual that described the measurement device and contained conceptual information meant to delineate the 6 factors.

Qualitive feedback was entirely positive.

A pdf version of the manual was distributed to the directors of Ericksonian training institutes across the world. A copy remains available at my website.



DEFINING THE TERMS

Tailoring *An ability to individualize treatment to accommodate client needs*

Utilization *An ability to recontextualize existing behaviors such that they serve some practical end*

Strategic *An ability to create a self-organized problem solving context*

Destabilization *An ability to disrupt stable psychological or behavioral patterns to encourage adaptive flexibility and learning*

Experiential *An ability to expand psychological structures using perceptual events rather than conceptual dialogue*

Naturalistic *An ability to create the expectation that positives changes can and will occur naturally or automatically—without the need for conscious effort*

THE MISSING THEORY

Jamesean Functionalism Consciousness creates behavioral changes that enables people to rapidly adapt to their environment, as well as organic changes that supports the evolution of the species (i.e., neuroplasticity).

- People are most likely to thrive while engaged in effortful problem solving and lifelong learning.

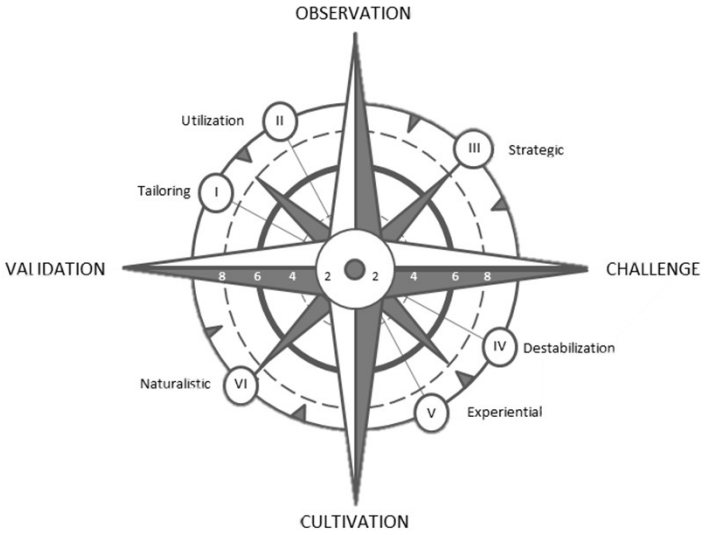
Pragmatism All thoughts and behaviors should be evaluated in terms of the physical outcomes they produce (i.e., outcome-informed decision making).

- Therapy should be outcome driven rather than theory driven. As soon as problematic behaviors are used to achieve practical outcomes, they cease to be "dysfunctional."

Principle of Variation William James, *"The line of health is not narrow! A peculiarity then, when it is recognized, should be welcome if it can be made useful."* Similar to the concept of genetic diversity, behaviorally and intellectually pluralistic societies are more likely to thrive. Diversity/novelty in life experience is equally as important for functional readiness in the individual (Short, 2019).

- Therapy should encourage client creativity, imagination, and idiosyncratic problem solving

PRACTICAL APPLICATIONS



Audience participation:

- Please identify and share a clinical scenario
- I will pick a relevant skill set
- Everyone is to think of how he/she would apply that particular skill, and I will do the same

Tailoring * Utilization * Strategic * Destabilization * Experiential * Naturalistic

LIMITATIONS OF THE RESEARCH AND POTENTIAL RISKS

At this time, Ericksonian therapy (ET) has only been tested in one RCT outcome study (Simpkins & Simpkins, 2008), which compared the outcome of ET against brief dynamic therapy (BDT). The study yielded no statistically meaningful difference between treatment conditions, with the exception of superior performance by ET on the Hopkins Symptom Checklist (HSCL), which measures symptoms people often get when they are suffering from fears, anxiety, and conflicts. More clinical trails are needed to establish replication of outcomes and efficacy for this treatment modality.

Recent research suggests that expressive-experiential therapies can lead to the exacerbation of painful emotions (Lilienfeld, 2007), if proper safeguards are not in place, while recovered-memory techniques run the risk of producing false memories of trauma (Lynn et al., 2003). Data from *recovered-memory legal claims* reveals that suicidal ideation increased nearly seven-fold and that psychiatric hospitalizations increased over five-fold over the course of therapy (Dineen, 2001). More research is needed on the steps that can be taken to mitigate each of these risks.

MITIGATING THE RISK OF PSYCHOTHERAPEUTIC METHODOLOGIES

It should be noted that approximately 10% of the treatment population report mental deterioration following participation in psychotherapy (Boisvert & Faust, 2003). This problem can be addressed by adhering to the following principles:

Use a formal, written survey at the end of each session to assess therapy effects and the status of the therapeutic alliance (Miller, et al., 2005) or (SAS-B, available at www.iamdrshort.com/sas.htm).

Never force knowledge, theories, ideas, or memories onto the client. Give a privileged status to the client's own self-knowledge and estimation of what he/she is ready to discuss or explore.

Provide a context in which the client can inform you of his/her psychological limitations and then respect those boundaries (e.g., treatment contract).

If there are painful memories that the client wishes to modify, make certain to obtain informed consent, seek to modify emotional reactions or problematic images associated with the event, while leaving the factual nature of the storyline intact. Never suggest the existence of a negative event that the client has not already identified as factual (Dineen, 2001; Lynn, et al., 2003).

Avoid any technique or procedure in which the client might feel trapped, threatened, verbally condemned, belittled, violated, emotionally injured, controlled, shamed or humiliated. The use of therapeutic directives, ordeals or psychological shock can result in mental deterioration or death if it violates any of these principles (Lilienfeld, 2007).

LIST OF REFERENCES

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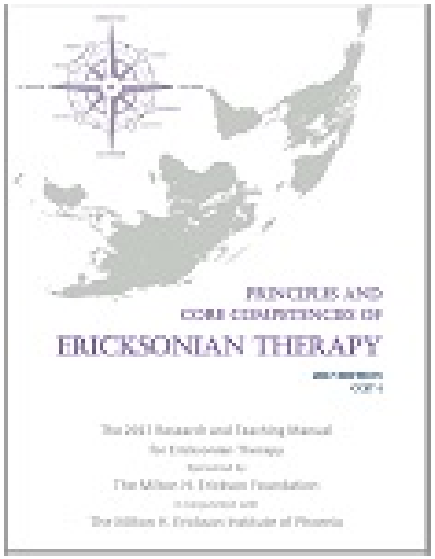
AVAILABLE RESOURCES

http://www.iamdrshort.com/PDF/Papers/Core%20Competencies%20Manual.pdf
or
http://www.iamdrshort.com/book.htm



English & Spanish versions, 136 pages

PRINCIPLES AND
CORE COMPETENCIES OF
ERICKSONIAN THERAPY

The 2017 Research and Teaching Manual
for Ericksonian Therapy

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