

# The Nature of Hypnosis

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## The Nature of Hypnosis

*A report prepared by a Working Party at the  
request of The Professional Affairs Board of  
The British Psychological Society*

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# Background

This paper has been prepared by a working party convened at the request of the Professional Affairs Board of the British Psychological Society. The scope of this document is to provide a considered statement about hypnosis and important issues concerning its application and practice in a range of contexts, notably for clinical purposes, forensic investigation, academic research, entertainment and training.

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# Introduction

Hypnosis is a valid subject for scientific study and research and a proven therapeutic medium. It is important that theoretical and practical issues and controversies that arise from the study and application of hypnosis are investigated, explained and understood from within the relevant mainstream scientific disciplines. This paper is a summary of what is known about the nature of hypnosis from an essentially non-theoretical standpoint, and addresses important issues that arise from its practice and application.

# The Nature of Hypnosis

The term 'hypnosis' denotes an interaction between one person, the 'hypnotist', and another person or people, the 'subject' or 'subjects'. In this interaction the hypnotist attempts to influence the subjects' perceptions, feelings, thinking and behaviour by asking them to concentrate on ideas and images that may evoke the intended effects. The verbal communications that the hypnotist uses to achieve these effects are termed 'suggestions'. Suggestions differ from everyday kinds of instructions in that they imply that a 'successful' response is experienced by the subject as having a quality of involuntariness or effortlessness. Subjects may learn to go through the hypnotic procedures on their own, and this is termed 'self-hypnosis'.

## Types of suggestion

Examples of suggestions are as follows.

### *Ideomotor suggestion*

The idea is conveyed of a simple, automatic movement of a part of the body, such as a finger or arm. Inhibition of a movement may also be suggested, such as arm immobility or eye catalepsy.

### *Suggestions of perceptual experiences*

In the case of ideosensory suggestion, coldness, numbness, warmth or heaviness, say, of the hand may be suggested. Visual experiences may also be suggested (e.g. 'Your best friend is sitting in front of you'). Similar suggestions may be offered in the auditory, olfactory and gustatory modalities. In the literature, responses to these kinds of suggestions are sometimes termed 'hallucinations' to convey the quality of realness that the responsive subject often reports.

### *Suggestions of complex experiences*

These include suggestions of reliving an early memory ('age regression') and the idea of progressing in time to some future event. Other suggestions include amnesia for all or some of the events during the hypnotic session, and time distortion (the idea that time is slowing down or speeding up).

### *Post-hypnotic suggestion*

With any of the above suggestions it may be stipulated that the response is to take place after the conclusion of hypnosis.

## Individual differences in responsiveness

People differ in the degree to which they respond to these procedures and their responsiveness may be measured by standardised psychometric scales.

## The hypnotic induction

A session of hypnosis normally begins with a 'hypnotic induction'. This usually consists of a series of suggestions that direct the subjects to relax and to become absorbed in their inner experiences, such as feelings, thoughts and imagery. During self-hypnosis subjects go through this process under their own direction.

# The Nature of Hypnosis (cont.)

The hypnotic induction procedure is considered to be important by many hypnotists, who argue that it is the presence of this procedure that truly defines a context as one involving 'hypnotic suggestion', rather than 'suggestion without hypnosis', or what is sometimes referred to as 'waking suggestion'.

## The importance of context

**The ways subjects respond to suggestions, and experience their responses, are strongly dependent on the demands and expectations created by the hypnotist and the context in which suggestions are given – the clinic, laboratory, forensic interview, on stage, and on a training course.**

## The concept of the 'hypnotic trance'

**Traditionally, it has been considered that the hypnotic induction places the subject in a special altered state of consciousness or 'trance', one property of which is enhanced responsiveness to suggestions. Modern research has called into question the validity of this way of thinking about hypnosis.**

Summaries of the relevant research and theorising may be found in the edited texts by Fromm & Nash (1992) and Lynn & Rhue (1991) and more recently in papers by Barber (2000) and Lynn & Sherman (2000).

Although studies *have* shown reliable psychological and physiological changes following hypnosis and in response to suggestions (Barabasz *et al.*, 1999; Crawford, Knebel & Vendemia, 1998; De Pascalis, 1999; Gruzelier, 1998) many would argue that it has not been convincingly demonstrated that these changes are *unique* to hypnosis or hypnotic suggestion. This area is currently the subject of experimental investigation in a number of research centres.

Despite this, the concept of 'trance' may be a useful term to denote the state of inner absorption and detachment from immediate realities that is usually encouraged by the hypnotic induction and often reported by the subject. In this sense it may be very similar to everyday 'trance' experiences, for example when one is absorbed in some music or a daydream, or engrossed in a book.

This state of absorption does not seem *necessary* for successful suggested responding (Kirsch, 1991), but it may be that it has some enhancing affect on suggestibility, although this has yet to be well established empirically.

In contrast, there is good evidence that other factors such as expectation and enhanced motivation make an important contribution to the increase in suggestibility often observed when the context has been defined as 'hypnosis' by the administration of some kind of induction procedure (Barber & Calverley, 1963a, 1963b, 1965; Glass & Barber, 1961; Kirsch, 1991; Orne, 1959).

**Whatever the case, although they may become very absorbed in the suggested ideas and images, subjects typically retain awareness of their environment and respond appropriately to it. Afterwards, they are usually able to recall most, if not all, of what they attended to during the session.**

The relationship between hypnosis and memory will be discussed in further detail in due course.

## **Hypnosis and will**

**Hypnotic procedures are not in themselves able to cause people to commit acts against their will. However, the demands of the context in which the procedures take place may exert pressure on the subject to comply with the hypnotist's instructions.**

Aside from studies on the coercive nature of the psychological experiment itself, evidence for the above assertions comes from studies on hypnosis by Levitt *et al.* (1975), O'Brian & Rabuck (1976) and Orne & Evans (1965).

It follows that any allegation that hypnosis caused a person to engage in activities against his or her will must be assessed from a careful consideration of non-hypnotic influences present in the context (Heap, 1995a; Hoëncamp, 1989; Orne, 1972).

# Experimental Research

Hypnosis is used in experimental settings either as an object of investigation in its own right or as a tool for exploring other psychological phenomena such as pain, memory, sensory alterations or the voluntary control of behaviour. More recently, hypnosis has been increasingly used in neuroimaging studies (mostly PET) as a means of manipulating subjective experience (Rainville *et al.*, 1997).

**There is no clear evidence that participants in laboratory studies of hypnosis are at a significantly greater risk of adverse effects than in other common types of psychological research.**

In laboratory-based studies it has been found that the majority of participants experiencing hypnosis on its own or as part of an experimental study report positive after-effects, particularly relaxation. A minority of participants (estimates range from 8 to 49 per cent) under these conditions report negative after-effects (e.g. headaches, dizziness, nausea, stiff necks: Brentar & Lynn, 1989; Crawford, Hilgard & Macdonald, 1982; Lynn, Martin, & Frauman, 1996) but these are no more frequently reported than after experimental psychological procedures not involving hypnosis (e.g. a verbal learning experiment: Brentar *et al.*, 1992; Lynn, Myer & Mackillop, 2000). Also, there is no demonstrable relationship between hypnotisability and the occurrence of negative after-effects (Lynn, Myer & Mackillop, 2000). In student populations, fewer negative after-effects are reported following hypnosis procedures than after other college activities, such as attending a lecture or taking an examination. Indeed, hypnosis is rated as the most pleasant experience when compared to these other activities (Lynn, Myer & Mackillop, 2000).

There is also evidence that investigations involving protracted and tedious procedures such as PET and fMRI scanning are experienced by the participants as being more tolerable when hypnosis is used (Friday & Kubal, 1990).

As with all experimental procedures involving humans, investigations in which hypnosis is to be used should be first approved by the appropriate Research Ethics Committee.

**The Ethics application should clearly state that hypnosis is to be used and the hypnotic procedures should be clearly described. Participant information sheets and consent forms should always be used and these should state what is known about the risk of negative after-effects in comparison to other procedures and should emphasise the fact that the participant is free to terminate the procedure at any time without having to give a reason.**

Although there is no evidence that hypnosis poses any greater risks to the participants than other psychological procedures, experimenters should be aware that any negative after-effects that may occur will likely be attributed by the participants and others to the use of hypnosis rather than to other factors related to the experimental situation or the participants themselves.

Experimenters should also be aware that some kinds of suggestions given during hypnosis may make some individuals more prone to the creation of false memories (see below) and that hypnosis may enhance affective responses to some stimuli, particularly those relating to the participant's past (Nash, 1987).

# Hypnosis and Memory

Traditionally, hypnosis has been associated with memory in two ways, namely the creation of amnesia (memory loss) and hypermnesia (memory enhancement).

Reports by subjects of amnesia over and above that due to normal memory loss can occur both during and after sessions of hypnosis. Reports of profound, spontaneous (i.e. unsuggested) amnesia during and following hypnosis are comparatively rare. Instead most hypnotic amnesia occurs following specific suggestions to forget given by the hypnotist. The forgotten material can normally be retrieved following a prearranged signal from the hypnotist, indicating that the phenomenon involves a disruption of memory retrieval rather than encoding. If no such signal is given, the amnesia will tend to dissipate with successive attempts to remember. The proportion of subjects who respond to a suggestion of posthypnotic amnesia depends on the measures adopted; on standard tests, when reversibility is taken into account, this may range from 25 per cent down to 10 per cent with increasing stringency of criteria (Kihlstrom & Register, 1984).

Researchers disagree about the exact mechanisms involved in the production of hypnotic amnesia. Some argue that amnesic subjects have temporarily lost control of their memory processes, and this is supported by the participants' own subjective reports (Cooper, 1972; Hilgard, 1986; Kihlstrom, 1978). Others point to evidence that many amnesic subjects will breach amnesia when under pressure to remember, or when the expectation to breach is created, thus indicating that they are responding to expectancy effects or are engaged in active attempts to forget (Coe & Sluis, 1989; Wagstaff & Frost, 1996).

The claim that hypnosis may have hypermnesic properties has led to its use by police forces in a number of countries in an attempt to enhance the memories of witnesses to crimes. Typically, however, forensic hypnosis interviews employ a variety of techniques that may, in the absence of hypnosis, be useful for helping witnesses to recall details. These include reinstating the context and allowing free, uninterrupted report. The important question, therefore, is 'What do hypnotic procedures add to memory enhancement techniques?'

Experimental research suggests that the addition of hypnosis often has no effects on memory (American Medical Association, 1985; Heap, 1988) but when there are effects, they tend to be confined to situations that require participants to freely recall meaningful materials, such as filmed crimes and staged incidents (Lynn & McConkey, 1998; Wagstaff, 1999). In such cases, the main effects may be:

- (i) Increased reports of both correct and incorrect information; hence, although participants may remember more correct information, they are not more accurate and, in fact, sometimes hypnosis may have a detrimental effect on accuracy; and
- (ii) Increased confidence of participants in the correctness of their reports, even though they may be inaccurate.

Because of the problems associated with these effects (American Medical Association, 1985) some states in the USA have banned from testifying in court witnesses who have previously been interviewed using hypnosis. In the UK no such ban is in operation, but in 1987 the Home Office introduced a set of draft guidelines on the use of hypnosis by the police for interviewing purposes (Home Office, 1987). In these guidelines it is argued, for example, that the accuracy of information obtained with hypnosis must be treated with the greatest caution; hence, hypnosis should only be used in serious cases as a last resort when all other methods of investigation have failed. Also, criminal suspects should not be considered for hypnosis under any circumstance and a witness who may be called upon to give evidence in court should

# Hypnosis and Memory *(cont.)*

not normally be considered for hypnosis. Regarding procedures, the guidelines state that, if hypnosis is employed, it should be conducted by a suitably qualified psychiatrist or clinical psychologist, and the whole interview must be videotaped.

Subsequently, in 1988, the Home Office issued a circular stating more definitively that, because of the risks attached to its use, hypnosis should be discouraged as a tool in police investigations (Home Office, 1988).

**In summary, there is no strong evidence that the introduction of hypnotic procedures accurately enhances the memory of a witness to a crime. Instead, hypnosis may result in false memories and misplaced confidence in recall. Consequently, if hypnosis is used at all for investigative purposes, any evidence elicited should be treated with the utmost caution.**

# Hypnosis in Therapy

The therapeutic use of hypnosis may be traced back to the practices of Franz Anton Mesmer in the 18th century. However, it was not until the middle of the 19th century that these practices began to resemble those used by therapists today.

## General nature of hypnotherapeutic procedures

Hypnotherapeutic approaches typically involve induction and deepening methods that usually emphasise mental and physical relaxation, and one or more of the following:

- (i) Suggestions to encourage desired changes in perception, feelings, thinking and behaviour;
- (ii) Suggestions and guided imagery techniques to explore possible problems and conflicts that underlie the presenting complaints;
- (iii) The use of self-hypnosis by the client or patient to rehearse relaxation and other self-control methods.

Hypnosis is best understood as a set of procedures that may be used by the practitioner to augment his or her therapeutic approaches to problems that fall within the scope of his or her professional work.

Hypnotherapeutic procedures resemble and overlap with other therapeutic methods such as covert behaviour therapy, meditation, relaxation therapy, autogenic training and guided imagery techniques. Hence it is not uncommon for two therapists to be using very similar procedures, one calling them 'hypnosis' and the other using one of the aforementioned terms.

## Applications of hypnosis in therapy and evidence of its effectiveness

Although accounts of the clinical applications of hypnosis have been published in books and journals over the last 150 years or so, it is only in the last 30 years that serious attempts have been made to evaluate the outcome of hypnotic procedures in groups of patients with specific problems. In such studies, hypnotic procedures have constituted the main component of treatment and have typically been directly targeted at symptom alleviation.

**Enough studies have now accumulated to suggest that the inclusion of hypnotic procedures may be beneficial in the management and treatment of a wide range of conditions and problems encountered in the practice of medicine, psychiatry and psychotherapy. In many cases, however, the relative contribution of factors specific to hypnosis is as yet unclear, and often the influence on outcome of the measured hypnotic susceptibility of the patients is small or insignificant.**

The results of clinical research may be summarised as follows:

There is convincing evidence that hypnotic procedures are effective in the management and relief of both acute and chronic pain and in assisting in the alleviation of pain, discomfort and distress due to medical and dental procedures (Blankfield, 1991; Genuis, 1995; Lang, Benotsch *et al.*, 2000; Lang, Joyce *et al.*, 1996; Montgomery, DuHamel & Redd, 2000; Walker *et al.*, 1991) and childbirth (Brann & Guzvica, 1987; Freeman *et al.*, 1986; Jenkins & Pritchard, 1993).

# Hypnosis in Therapy (cont.)

Hypnosis and the practice of self-hypnosis may significantly reduce general anxiety, tension and stress in a manner similar to other relaxation and self-regulation procedures (Schoenberger, 2000). Likewise, hypnotic treatment may assist in insomnia in the same way as other relaxation methods (Anderson, Dalton & Basker, 1979; Stanton, 1989).

There is encouraging evidence demonstrating the beneficial effects of hypnotherapeutic procedures in alleviating the symptoms of a range of complaints that fall under the heading 'psychosomatic illness'. These include tension headaches and migraine (Alladin, 1988; Holroyd & Penzien, 1990; ter Kuile *et al.*, 1994); asthma (see review of clinical studies by Hackman, Stern & Gershwin, 2000); gastro-intestinal complaints such as irritable bowel syndrome (Galovski & Blanchard, 1998; Harvey *et al.*, 1989; Whorwell, Prior, & Colgan, 1987; Whorwell, Prior & Faragher, 1984); warts (DuBreuil & Spanos, 1993); and possibly other skin complaints such as eczema, psoriasis and urticaria (Shertzer & Lookingbill, 1987; Stewart & Thomas, 1995; Zachariae *et al.*, 1996).

Hypnosis is probably at least as effective as other common methods of helping people to stop smoking (see review by Green & Lynn, 2000). Meta-analyses by Law & Tang (1995) and Viswesvaran & Schmidt (1992) give mean abstinence rates for hypnosis at 23 per cent and 36 per cent respectively. There is evidence from several studies that its inclusion in a weight reduction programme may significantly enhance outcome (Bolocofsky, Spinler & Coulthard-Morris, 1985; Kirsch, Montgomery & Sapirstein, 1995; Levitt, 1993).

There have been fewer studies specifically on children, but the available evidence suggests that the above conclusions may be extended to children and young people (Hackman, Stern, & Gershwin, 2000; Sokel *et al.*, 1993; Stewart & Thomas, 1995; see also review by Milling & Costantino, 2000).

Too few studies have been published investigating the adjunctive use of hypnosis in broader psychotherapeutic programmes for the treatment of specific psychological disorders such as depression, sexual dysfunction and disorder, anorexia nervosa, bulimia nervosa, speech and language disorders, posttraumatic stress disorder and phobic disorders. A similar statement may be made concerning its use in sports psychology.

The above conclusions are provisional, as research on the clinical effectiveness of hypnosis is continuing with improved methodology.

## Risks and safeguards in therapeutic practice

**Hypnosis is generally a benign procedure and considerations of potential risks resemble those for other similar psychological methods.**

Much of the literature regarding risks is anecdotal, but some important general considerations are as follows.

When hypnosis is being used to treat medical problems and pain, it is essential that the patient has had a thorough medical examination and is receiving the appropriate medical treatment. During hypnosis, the patient should have immediate access to any emergency medication he or she has been prescribed, such as asthma inhalers.

Patients with mental illnesses should have already undergone a proper mental state examination and been offered the appropriate medication.

There are a few reports of the therapeutic application of hypnosis with psychotic patients, although its use with such patients is generally avoided. As with psychotherapy generally, hypnosis should only be used with psychotic patients by those therapists who are highly experienced in hypnosis and in working psychotherapeutically with such patients.

Contrary to earlier accounts, hypnosis may be used adjunctively in the psychological treatment of some depressed patients. However, care should be exercised to avoid subjecting the depressed patient to undue distress by, for example, the use of hypnoanalytical procedures that may exacerbate suicidal ideation.

During hypnotherapeutic procedures such as regression methods, a patient may become very emotional and may abreact. This has occasionally been reported to occur spontaneously in therapy, without the suggestion of reliving any memory. Therapists should, therefore, be knowledgeable and skilled in assisting patients who are in a state of extreme emotion.

The dangers of regression methods in eliciting false memories are considered under the next heading. Guidelines have now been drawn up by the American Society of Clinical Hypnosis (Hammond *et al.*, 1995) and the British Society of Experimental and Clinical Hypnosis (Oakley & Degun-Mather, 1997)

Hypnosis should not be routinely used as an investigative device for the diagnosis of multiple personality disorder (MPD), now known as dissociative identity disorder (DID). While the diagnosis of MPD or DID has relied to a significant degree on the use of hypnosis, concern has been expressed that this, along with demands and expectations, may encourage multiple role enactments by the patient (Spano & Burgess, 1994). Also, the existence of MPD or DID as a separate psychiatric disorder has been seriously called into question (Aldridge-Morris, 1989; Piper, 1994).

## **Hypnosis and memory in therapy**

There are many reasons why memories may be the focus of attention during therapy. Frequently, the patient's presenting problems are attributed to past events and, although some therapeutic approaches do not consider it necessary to address these, others involve their exploration.

The value of hypnotic procedures in facilitating relaxation is well established, and a client who is enjoying a sense of calmness and safety is likely to be better able to disclose and work through difficult material. Some therapeutic approaches encourage the client to relive a memory in order to rehearse a different outcome, such as a more effective means of coping with the problem encountered or the ventilation of unexpressed feelings.

It is normally assumed that the events in question are readily remembered by the client. There are, however, occasions in therapy when recalling significant memories may prove difficult, as when the client finds the material too embarrassing or painful, or when he or she has limited recall of the events, or is unable to remember any relevant events at all. In such circumstances the use of hypnosis is sometimes considered to be appropriate.

When hypnosis is used to help the subject or client recall events from an earlier developmental period, the term 'age regression' is often used. Although it may have a legitimate role to play in the above therapeutic approaches, it must be stressed that age regression does not literally reinstate in the subject the stage of neurological, neuropsychological or cognitive development corresponding to the age targeted (Nash, 1987).

# Hypnosis in Therapy (cont.)

The above techniques are always undertaken with the client's knowledge and understanding of their purpose. One problem with any method involving guided imagery, however, is that a therapist may encourage the development of fantasies that are not recognised as such either by the therapist or the client (Laurence & Perry 1983). A further problem may be 'source amnesia'; this occurs very occasionally when, in the posthypnotic stage, the subject retains new information but apparently forgets that this was acquired during hypnosis (Evans, 1979).

Small, unwitting changes or embellishments to memories may be harmless, but it is important that the therapist be aware of the possibility of such effects when using hypnosis in this way. There is considerable potential for harm when hypnosis is used on the assumption that it facilitates the recollection of events when no conscious memories of these events exist in the first place. Current understanding of memory processes is inadequate to state unequivocally whether or not it is possible for a memory to be repressed out of all awareness, yet to be accessible through hypnotic techniques. However, much evidence suggests that this is implausible (Holmes, 1990; Pope & Hudson, 1995). What is incontrovertible is that using hypnosis in this way carries a real risk of producing substantial pseudo-memories. Sometimes, these may have such a bizarre quality (e.g. 'memories' of alien abduction) that they would be dismissed by any reasonable person, but some can be so plausible as to beguile the therapist and client alike into accepting them as accurate. This problem has received a high profile in the so-called 'Recovered Memories' debate (Conway, 1997; Ofshe & Watters, 1994).

For a therapist merely to claim awareness of the problem and to be guarding against it provides insufficient protection against the dangers of false memory. Research has shown that simply to label a situation 'hypnotic' will cause people who are attempting to recall their earliest memories to produce many more very early recollections, with a significant proportion claimed to be from before the age of twelve months (Green, 1999; see also Marmelstein & Lynn, 1999). This is so far within the accepted period of infantile amnesia (Howe & Courage, 1993; Usher & Neisser, 1993) as to make it virtually certain that the recalled memories are false.

It is the public's expectation that hypnosis will facilitate the recall of forgotten events (Johnson & Hauck, 1999; Wagstaff, 1988); hence memories of events, true or false, are generated. A therapist cannot effectively educate a client that hypnosis does not have that power, when he or she then proceeds to use it in a search for unavailable memories.

**In summary, hypnosis does not have any special property for enhancing memory in therapy, as in any other context. There are circumstances in which the ingredients of hypnosis, such as a sense of relaxation and well-being, may justify its use during a period of recollection. Hypnotic procedures may be helpful for reviewing and restructuring existing memories of events that are associated with the client's problems. However, in these situations, the potential for producing confidently held, but inaccurate, memories must be recognised. Hypnosis should not be used on the assumption that it can recover memories of events of which the client has no recollection but which are the cause of his or her presenting problems.**

**Professional and ethical considerations in the therapeutic practice of hypnosis**  
**Anyone using hypnosis for therapeutic purposes should confine its application to those problems that he or she is professionally qualified to treat. A sensible rule to follow is only to use hypnosis for the treatment of those problems that one would be qualified to treat without the use of hypnosis.**

Where a professional person is offering hypnosis to augment a broader course of counselling or psychotherapy, he or she should already possess recognised qualifications in that field of counselling or psychotherapy.

When undertaking hypnosis with any patient or client, the professional practitioner should always adhere to the ethical rules of his or her own professional organisation.

In addition, the professional should adhere to a set of ethical guidelines typified by the International Society of Hypnosis Ethical Code (International Society of Hypnosis, 1997) or one derived from it.

### **Training in the therapeutic application of hypnosis**

Training in hypnosis should only be undertaken on the understanding that hypnosis is a set of procedures that may be used to augment one of the established psychological therapies or to facilitate psychological procedures in medicine and dentistry.

**Training in hypnosis for the purposes of applying it therapeutically should, therefore, only be undertaken by individuals who already possess, or are in the process of acquiring, professional qualifications and experience in understanding and treating those problems for which they intend using hypnosis.**

Trainees should agree to abide by an ethical code exemplified by that of the International Society of Hypnosis.

Psychologists who are trained in the therapeutic use of hypnosis should be encouraged to adhere to their existing professional title (e.g. 'clinical psychologist', 'educational psychologist', or 'counselling psychologist') rather than use the designation 'hypnotherapist'.

While there are university-based Diploma and M.Sc. courses that teach the use of hypnosis as an adjunct to the trainees' existing clinical and professional skills, there are currently no training courses in clinical hypnosis that have any form of substantive professional recognition.

**Professionals wishing to train in hypnosis should satisfy themselves that any training they intend to do is sufficient for the purposes for which they wish to use hypnosis and is consistent with the professional guidelines contained in this paper. Those professionals who offer training should only do so on that basis.**

# Stage Hypnosis

Stage hypnosis is a form of entertainment in which the hypnotist suggests to the participants that they are having certain experiences, or are engaging in certain activities, that are calculated to amuse the audience. This usually demands an immediate and flamboyant response to the suggestions.

The hypnotist selects his or her participants from the audience, usually by simple suggestibility tests. High suggestibility, however, is not necessarily a characteristic of any single participant (Crawford *et al.*, 1992).

The hypnotist may perform an induction but some find this unnecessary (Heap, 2000a). This is consistent with existing knowledge about the nature of hypnosis (Kirch, 1991).

Some concerns have been expressed about possible adverse effects of stage hypnosis (Echterling & Emmerling, 1987; Heap 2000a; MacHovec, 1986; Waxman, 1988). Participants are often very surprised by their experiences and they may have both pleasant and unpleasant reactions. The context may make it difficult for some participants to decline to respond or to disengage completely if they wish. Some participants may report that they felt as if they were controlled by the hypnotist and may therefore regret taking part. A stage hypnotist could unwittingly suggest an experience that the participant would normally find upsetting.

Some published accounts have described longer-lasting psychological problems and disorders associated with stage hypnosis (Kleinhauz & Beran, 1981, 1984), and occasionally participants, and even spectators, have made this claim, either in the media or through legal action. However, in general, the role of stage hypnosis in causing such problems has not been convincingly demonstrated (Heap, 1995b, 2000b; Wagstaff, 2000).

The UK Home Office has a set of model conditions and safeguards to be attached to licences issued under the Hypnotism Act (Her Majesty's Stationery Office, 1952). These were revised in 1996 (Home Office, 1996) by a panel of psychologists and psychiatrists who, after reviewing the evidence, concluded that stage hypnosis does not pose a significant risk to participants (Home Office, 1995).

**In summary, therefore, although people may sometimes react negatively to stage hypnosis, it does not appear to pose a mental health risk to participants and members of the audience if the above model conditions are in place.**

# References

- Aldridge-Morris, R. (1989). *Multiple personality disorder: An exercise in deception*. Hove: Erlbaum.
- Alladin, A. (1988). Hypnosis in the treatment of head pain. In M Heap (Ed.), *Hypnosis: Current clinical, experimental and forensic practices* (pp. 159–166). London: Croom Helm.
- American Medical Association (1985). Council on Scientific Affairs report on 'Scientific status of refreshing memories by the use of hypnosis'. *Journal of the American Medical Association*, 253, 1918–1923.
- Anderson, J.A.D., Dalton, E.R. & Basker, M.A. (1979). Insomnia and hypnotherapy. *Journal of the Royal Society of Medicine*, 72, 734–739.
- Barabasz, A., Barabasz, M., Jensen, S., Calvin, S., Trivisan, M. & Warner, D. (1999). Critical event-related potentials show the structure of hypnotic suggestions is crucial. *International Journal of Clinical and Experimental Hypnosis*, 47, 5–22.
- Barber, T.X. (2000). A deeper understanding of hypnosis: Its secrets, its nature, its essence. *American Journal of Clinical Hypnosis*, 42, 208–272.
- Barber, T.X. & Calverley, D.S. (1963a). The relative effectiveness of task motivating instructions and trance induction procedure in the production of 'hypnotic like' behavior. *Journal of Nervous and Mental Disease*, 137, 107–116.
- Barber, T.X. & Calverley, D.S. (1963b). Toward a theory of hypnotic behavior: Effects on suggestibility of task motivating instructions and attitudes toward hypnosis. *Journal of Abnormal and Social Psychology*, 67, 557–565.
- Barber, T.X. & Calverley, D.S. (1965). Empirical evidence for a theory of 'hypnotic' behavior: Effects on suggestibility of five variables typically included in hypnotic induction procedures. *Journal of Consulting Psychology*, 29, 98–107.
- Blankfield, R.P. (1991). Suggestion, relaxation, and hypnosis as adjuncts to the care of surgery patients: A review of the literature. *American Journal of Clinical Hypnosis*, 33, 172–186.
- Bolocofsky, D.N., Spinler, D. & Coulthard-Morris L. (1985). Effectiveness of hypnosis as an adjunct to behavioral weight management. *Journal of Clinical Psychology*, 41, 35–41.
- Brann, L.R. & Guzvica, S.A. (1987). Comparison of hypnosis and conventional relaxation for antenatal and intrapartum use: A feasibility study in general practice. *Journal of the Royal College of General Practitioners*, 37, 437–440.
- Brentar, J. & Lynn, S.J. (1989). 'Negative' effects and hypnosis: A critical review. *British Journal of Experimental and Clinical Hypnosis*, 6, 75–84.
- Brentar, J., Lynn, S.J., Carlson, B. & Kurzahls, R. (1992). Controlled research on hypnotic aftereffects: The Post-Hypnotic Experience Questionnaire. In W. Bongartz (Ed.), *Hypnosis: 175 years after Mesmer* (pp. 179–201). Konstanz: University of Konstanz Press.
- Coe, W.C. & Sluis, A. (1989). Increasing contextual pressures to breach posthypnotic amnesia. *Journal of Personality and Social Psychology*, 57, 885–894.
- Conway, M.A. (Ed.) (1997). *Recovered memories and false memories*. Oxford: Oxford University Press.
- Cooper, L.M. (1972). Hypnotic amnesia. In E. Fromm & R.E. Shor (Eds.), *Hypnosis: Research developments and perspectives* (pp. 217–252). Chicago: Aldine-Atherton.
- Crawford, H.J., Hilgard, J.R. & Macdonald, H. (1982). Transient experiences following hypnotic testing and special termination procedures. *International Journal of Clinical and Experimental Hypnosis*, 26, 117–126.
- Crawford, H.J., Kitner-Triolo, M., Clarke, S.W. & Olesko, B. (1992). Transient positive and negative experiences accompanying stage hypnosis. *Journal of Abnormal Psychology*, 101, 663–667.
- Crawford, H., Knebel, T. & Vendemia, M.C. (1998). The nature of hypnotic analgesia: Neurophysiological foundation and evidence. *Contemporary Hypnosis*, 15, 22–33.
- De Pascalis, V. (1999). Psychophysiological correlates of hypnosis and hypnotic susceptibility. *International Journal of Clinical and Experimental Hypnosis*, 47, 117–143.
- DuBreuil, S. & Spanos, N.P. (1993). Psychological treatment of warts. In J.W. Rhue, S.J. Lynn & I. Kirsch (Eds.), *Handbook of clinical hypnosis* (pp. 623–643). Washington DC: American Psychological Association.

# References (cont.)

- Echterling, L.G. & Emmerling, D.A. (1987). Impact of stage hypnosis. *American Journal of Clinical Hypnosis*, 29, 149–154.
- Evans, F.J. (1979). Contextual forgetting: Posthypnotic source amnesia. *Journal of Abnormal Psychology*, 88, 556–563.
- Freeman, R.M., MacCauley A.J., Eve, L. & Chamberlain, G.V.P (1986). Randomised trial for analgesia in labour. *British Medical Journal*, 292, 657–658.
- Friday, P.J. & Kubal, W.S. (1990). Magnetic resonance imaging: Improved patient tolerance utilizing medical hypnosis. *American Journal of Clinical Hypnosis*, 33, 80–84.
- Fromm, E. & Nash, M.R. (1992). *Contemporary hypnosis research*. New York: Guilford Press.
- Galovski, T.E. & Blanchard, E.B. (1998). The treatment of irritable bowel syndrome with hypnotherapy. *Applied Physiology and Biofeedback*, 23, 219–232.
- Genuis, M.L. (1995). The use of hypnosis in helping cancer patients control anxiety, pain and emesis: A review of recent empirical studies. *American Journal of Clinical Hypnosis*, 37, 316–325.
- Glass, L.B. & Barber, T.X. (1961). A note on hypnotic behavior, the definition of the situation, and the placebo-effect. *Journal of Nervous and Mental Disease*, 132, 539–541.
- Green, J.P. (1999). Hypnosis, context effects, and the recall of early autobiographical memories. *International Journal of Clinical and Experimental Hypnosis*, 47, 284–300.
- Green, J.P. & Lynn, S.J. (2000). Hypnosis and suggestion-based approaches to smoking cessation: An examination of the evidence. *International Journal of Clinical and Experimental Hypnosis*, 48, 195–224.
- Gruzelier, J. H. (1998). A working model of the neurophysiology of hypnosis: A review of evidence. *Contemporary Hypnosis*, 15, 5–23.
- Hackman, R.M., Stern, J.S., & Gershwin, M.E. (2000). Hypnosis and asthma: A critical review. *Journal of Asthma*, 37, 1–15.
- Hammond, D.C., Garver, R.B., Mutter, C.B. et al. (1995). *Clinical hypnosis and memory: Guidelines for clinicians and for forensic hypnosis*. Des Plaines, IL: American Society of Clinical Hypnosis Press.
- Harvey, R.F., Hinton, R.A., Gunary, R. & Barry, R.E. (1989). Individual and group hypnotherapy in the treatment of refractory irritable bowel syndrome. *Lancet*, 1, 424–425.
- Heap, M. (Ed.) (1988). *Hypnosis: Current clinical, experimental and forensic practices*. London: Croom Helm.
- Heap, M. (1995a). Another case of indecent assault by a lay hypnotherapist. *Contemporary Hypnosis*, 12, 92–98.
- Heap, M. (1995b). A case of death following stage hypnosis: Analysis and implications. *Contemporary Hypnosis*, 12, 99–110.
- Heap M. (2000a). The alleged dangers of stage hypnosis. *Contemporary Hypnosis*, 17, 117–126.
- Heap, M. (2000b). A legal case of a man complaining of an extraordinary sexual disorder following stage hypnosis. *Contemporary Hypnosis*, 17, 143–149.
- Her Majesty's Stationery Office (1952). *Hypnotism Act*. London: HMSO.
- Hilgard, E.R. (1986). *Divided consciousness: Multiple controls in human thought and action*. New York: Wiley.
- Hoëncamp, E (1989). Sexual coercion and the role of hypnosis in the abused therapeutic relationship. In D. Waxman, D. Pedersen, I. Wilkie & P. Mellett (Eds.), *Hypnosis: The Fourth European Congress at Oxford* (pp. 160–174). London: Whurr Publishers.
- Holmes, D.S. (1990). The evidence for repression: An examination of sixty years of research. In J.L. Singer (Ed.), *Repression and dissociation: Implications for personality theory, psychotherapy, and health* (pp. 85–102). Chicago: University of Chicago Press.
- Holroyd, K.A. & Penzien, D.B. (1990). Pharmacological versus non-pharmacological prophylaxis of recurrent migraine headache: A meta-analytic review of clinical trials. *Pain*, 42, 1–13.
- Home Office (1987). Draft circular: The use of hypnosis by the police in the investigation of crime. *British Journal of Experimental and Clinical Hypnosis*, 4, 189–191.
- Home Office (1988). Circular No. 66/1988: *The use of hypnosis by the police in the investigation of crime*. London: Home Office.

- Home Office (1995). *Report of the Expert Panel appointed to consider the effects of participation in performances of stage hypnosis*. London: Home Office.
- Home Office (1996). *Model conditions to be attached to licences for the performance of stage hypnotism*. Annex to Home Office Circular No 39/1996. London: Home Office.
- Howe, M.L. & Courage, M.L. (1993). On resolving the enigma of infantile amnesia. *Psychological Bulletin*, 113, 305–326.
- International Society of Hypnosis (1997). *Membership directory*. West Heidelberg, Australia: International Society of Hypnosis.
- Jenkins, M.W. & Pritchard, M.H. (1993). Hypnosis: Practical applications and theoretical considerations in normal labour. *British Journal of Obstetrics and Gynaecology*, 100, 221–226.
- Johnson, M.E. & Hauck, C. (1999). Beliefs and opinions about hypnosis held by the general public: A systematic evaluation. *American Journal of Clinical Hypnosis*, 49, 10–21.
- Kihlstrom, J.F. (1978). Context and cognition in posthypnotic amnesia. *International Journal of Clinical and Experimental Hypnosis*, 26, 246–267.
- Kihlstrom, J.F. & Register, P.A. (1984). Optimal scoring of amnesia on the Harvard Group Scale of Hypnotic Susceptibility, Form A. *International Journal of Clinical and Experimental Hypnosis*, 32, 51–57.
- Kirsch, I. (1991). The social learning theory of hypnosis. In S.J. Lynn & J.W. Rhue (Eds.), *Theories of hypnosis: Current models and perspectives* (pp. 439–466). New York: Guilford Press.
- Kirsch, I., Montgomery, G. & Sapirstein, G. (1995). Hypnosis as an adjunct to cognitive-behavioral psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, 63, 214–220.
- Kleinhauz, M. & Beran, B. (1981). Misuses of hypnosis: A medical emergency and its treatment. *International Journal of Clinical and Experimental Hypnosis*, 29, 148–161.
- Kleinhauz, M. & Beran, B. (1984). Misuse of hypnosis: A factor in psychopathology. *American Journal of Clinical Hypnosis*, 26, 283–290.
- Lang, E.V., Benotsch, E.G., Fick, L.J., Lutgendorf, S., Berbaum, M.L., Berbaum, K.S., Logan, H. & Spiegel, D. (2000). Adjunctive nonpharmacological analgesia for invasive medical procedures: A randomised trial. *Lancet*, 355, 1486–1490.
- Lang, E., Joyce, J.S., Spiegel, D., Hamilton, D. & Lee, K.K. (1996) Self-hypnotic relaxation during interventional radiological procedures: Effects on pain perception and intravenous drug use. *International Journal of Clinical and Experimental Hypnosis*, 44, 106–119.
- Laurence, J.-R. & Perry, C. (1983). Hypnotically created memory among highly hypnotizable subjects. *Science*, 523–524.
- Law, M. & Tang, J.L. (1995). An analysis of the effectiveness of interventions intended to help people stop smoking. *Archives of Internal Medicine*, 155, 1933–1941.
- Levitt, E. E. (1993) Hypnosis in the treatment of obesity. In J.W. Rhue, S.J. Lynn & I. Kirsch (Eds.), *Handbook of clinical hypnosis* (pp. 533–553). Washington DC: American Psychological Association.
- Levitt, R.E., Aronoff, G., Morgan, C.D., Overley, T.M. & Parrish, M.J. (1975). Testing the coercive power of hypnosis: Committing objectionable acts. *International Journal of Clinical and Experimental Hypnosis*, 23, 59–67.
- Lynn, S.J., Martin, D.J. & Frauman, D.C. (1996). Does hypnosis pose special risks for negative effects? *International Journal of Clinical and Experimental Hypnosis*, 44, 7–19.
- Lynn, S.J. & McConkey, K.M. (Eds.) (1998). *Truth in memory*. Guilford: New York.
- Lynn, S.J., Myer, E. & Mackillop, J. (2000). The systematic study of negative post-hypnotic effects: Research hypnosis, clinical hypnosis and stage hypnosis. *Contemporary Hypnosis*, 17, 127–131.
- Lynn, S.J. & Sherman, S.J. (2000). The clinical importance of sociocognitive models of hypnosis: Response set theory and Milton Erickson's strategic interventions. *American Journal of Clinical Hypnosis*, 42, 294–315.
- Lynn, S.J. & Rhue, J.W. (Eds.) (1991). *Theories of hypnosis: Current models and perspectives*. New York: Guilford Press.

# References (cont.)

- MacHovec, F.J. (1986). *Hypnosis complications: Prevention and risk management*. Springfield, IL: Charles C. Thomas.
- Marmelstein, L.R. & Lynn, S.J. (1999). Normative, group, and hypnotic influences on early autobiographical memory reports. *International Journal of Clinical and Experimental Hypnosis*, 47, 301–319.
- Milling, L.S. & Costantino, C.A. (2000). Clinical hypnosis with children: First steps toward empirical support. *International Journal of Clinical and Experimental Hypnosis*, 48, 113–137.
- Montgomery, G. H., DuHamel, K.N. & Redd, W.H. (2000). A meta-analysis of hypnotically induced analgesia: How effective is hypnosis? *International Journal of Clinical and Experimental Hypnosis*, 48, 138–153.
- Nash, M. (1987). What, if anything, is regressed about hypnotic age regression? A review of the empirical literature. *Psychological Bulletin*, 102, 42–52.
- Oakley, D.A. & Degun-Mather, M. (1997). *Clinical hypnosis and memory*. Document prepared by the British Society of Experimental Hypnosis.
- O'Brian, R.M. & Rabuck, S.J. (1976). Experimentally produced self-repugnant behavior as a function of hypnosis and waking suggestion: A pilot study. *American Journal of Clinical Hypnosis*, 18, 272–276.
- Ofshe, R. & Watters, E. (1994). *Making monsters: False memories, psychotherapy and sexual hysteria*. Berkeley CA: University of California Press.
- Orne, M.T. (1959). The nature of hypnosis: Artifact and essence. *Journal of Abnormal and Social Psychology*, 58, 277–299.
- Orne, M.T. (1972). Can a hypnotised subject be compelled to carry out otherwise unacceptable behavior? *International Journal of Clinical and Experimental Hypnosis*, 20, 101–117.
- Orne, M.T. & Evans, F.J. (1965). Social control in the psychological experiment: Antisocial behavior and hypnosis. *Journal of Personality and Social Psychology*, 1, 189–200.
- Piper, A. (1994). Multiple personality disorder. *British Journal of Psychiatry*, 164, 600–612.
- Pope, H.G. & Hudson, J.I. (1995). Can memories of childhood abuse be repressed? *Psychological Medicine*, 25, 121–126.
- Rainville, P., Duncan, G.H., Price, D.D., Carrier, B. & Bushnell, M.C. (1997). Pain affect encoded in human anterior cingulate but not somatosensory cortex. *Science*, 277, 968–971.
- Schoenberger, N.E. (2000). Research on hypnosis as an adjunct to cognitive-behavioral psychotherapy. *International Journal of Clinical and Experimental Hypnosis*, 48, 154–169.
- Shertzer, C.L. & Lookingbill, D.P. (1987). Effects of relaxation therapy and hypnotisability in chronic urticaria. *Archives of Dermatology*, 123, 913–916.
- Sokel, B., Christie, D., Kent, A., Lansdown, R., Atherton, D., Glover, M. & Knibbs, J. (1993). A comparison of hypnotherapy and biofeedback in the treatment of childhood atopic eczema. *Contemporary Hypnosis*, 10, 145–154.
- Spano, N.P. & Burgess, C. (1994). Hypnosis and multiple personality disorder. In S.J. Lynn & J.W. Rhue (Eds.), *Dissociation: Clinical and theoretical perspectives* (pp. 136–155). New York: Guilford Press.
- Stanton, H.E. (1989). Hypnotic relaxation and insomnia: A simple solution? *Hypnos: Swedish Journal for Hypnosis in Psychotherapy and Psychosomatic Disorders*, 16, 98–103.
- Stewart, A. & Thomas, S.E. (1995). Hypnotherapy as a treatment for atopic eczema in adults and children. *British Journal of Dermatology*, 132, 778–783.
- ter Kuile, E.G., Spinhoven, P., Linssen, A.C.G., Zitman, F.G., Van Dyck, R. & Rooijmans, H.G.M. (1994). Autogenic training and cognitive self-hypnosis for the treatment of recurrent headaches in three different subject groups. *Pain*, 58, 331–340.
- Usher, J.A. & Neisser, U. (1993). Childhood amnesia and the beginnings of memory for four early life events. *Journal of Experimental Psychology: General*, 122, 155–165.
- Viswesvaran, C. & Schmidt, F. (1992). A meta-analytic comparison of the effectiveness of smoking cessation methods. *Journal of Applied Psychology*, 77, 554–561.

- Wagstaff, G.F. (1988). Public conceptions of forensic hypnosis: Implications for education and practice. In M. Heap (Ed.) *Hypnosis: Current clinical, experimental and forensic practices* (pp. 395–403). London: Croom Helm.
- Wagstaff, G.F. (1999). Hypnosis and forensic psychology. In I. Kirch, A. Capafons, E. Cardeña-Buelna, S. Amigó (Eds.) *Clinical hypnosis and self-regulation: Cognitive-behavioral perspectives* (pp. 277–310). Washington DC: American Psychological Association.
- Wagstaff, G.F. & Frost, R. (1996). Reversing and breaching posthypnotic amnesia and hypnotically created pseudomemories. *Contemporary Hypnosis*, 13, 191–197.
- Walker, L.G., Lolley, J., Dawson, A.A. & Ratcliffe, M.A. (1991). Hypnotherapy for chemotherapy side-effects: Further developments. In M. Heap (Ed.), *Hypnotic contributions: Proceedings of the Seventh Annual Conference of the British Society of Experimental and Clinical Hypnosis* (pp. 63–71). Sheffield: BSECH Publication.
- Waxman, D. (1988). The problems of stage hypnotism. In M. Heap (Ed.), *Hypnosis: Current clinical, experimental and forensic practices* (pp. 426–433). London: Croom Helm.
- Whorwell, P.J., Prior, A. & Faragher, E.B. (1984). Controlled trial of hypnotherapy in the treatment of severe refractory irritable bowel syndrome. *Lancet*, 2, 1232–1234.
- Whorwell, P.J., Prior, A. & Colgan, S. M. (1987). Hypnotherapy in severe irritable bowel syndrome: Further experience. *Gut*, 28, 423–425.
- Zachariae, R., Øster, H., Bjerring, P. & Kragballe, K. (1996). Effects of psychological interventions on psoriasis: A preliminary report. *Journal of the American Academy of Dermatology*, 34, 1008–1015.

# THE SOCIETY

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The British Psychological Society was founded in 1901 and incorporated by Royal Charter in 1965.

## **Its principal objects are to:**

- promote the advancement and diffusion of a knowledge of psychology pure and applied;
- promote the efficiency and usefulness of Members of the Society by setting up a high standard of professional education and knowledge;
- maintain a Code of Conduct for the guidance of Members;
- compel the observation of strict rules of professional conduct;
- maintain a Register of Chartered Psychologists.

## **The Society has 35,500 members and:**

- has branches in England, Northern Ireland, Scotland and Wales;
- accredits nearly 700 undergraduate degrees;
- accredits nearly 100 postgraduate professional training courses;
- accredits higher degrees, in partnership with the Open University Validation Service;
- confers Fellowships for distinguished achievements;
- confers Chartered Status for professionally qualified psychologists;
- awards grants to support research and scholarship;
- publishes 10 scientific journals;
- publishes books, CD-ROMS, videos and other educational resources;
- publishes *The Psychologist* each month;
- publishes newsletters for its constituent groups;
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- all its members will contribute so that the strengths and diversity of its membership are fully utilised.

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