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HYPNOTIZABILITY AND THE USE OF TRADITIONAL DHAMI-JHANKRI HEALING IN NEPAL

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Abstract: This study examined the role of hypnotic responsiveness in the practice of a dhami-jhankri, a traditional Nepali healer. The hypnotic capacity of 248 male patients was measured in an allopathic (Western) clinic, an Ayurvedic (ancient Hindu healing art) clinic, and a dhami-jhankri’s practice. Hypnotizability was assessed using the Hypnotic Induction Profile (HIP). The Induction scores of the HIP were significantly higher among the dhami-jhankri’s patients than among either the Ayurvedic or allopathic patients. Furthermore, patients who returned to the dhami-jhankri were more highly hypnotizable than first-time dhami-jhankri patients. In addition, treatment satisfaction as reported by dhami-jhankri patients was positively correlated with HIP scores. The authors conclude that hypnotic phenomena as measured in the West might be an important component of the dhami-jhankri’s treatment in the East.

INTRODUCTION

Healing practices different from the allopathic, or Western bioscientific, model of medicine continue to be used around the world. The choice of the practice seems to be relatively unrelated to education level (Eisenberg et al., 1993; Skultans, 1988; Subedi, 1989). Optimizing medical care requires an understanding of the alternative health systems any particular patient may be using. It is therefore imperative to search for the basis of any efficacy, perceived or objective, in these alternative systems. There have been suggestions that some healers use techniques in their treatment of patients that are analogous to what we in the West call hypnosis (Bergman, 1973; Edgerton, 1971; Hofer, 1973). Hypnosis has been successfully used in allopathic medical practice for some time as
part of treatment strategies for illnesses ranging from migraine to irritable bowel to breast cancer (Andreychuk & Skriver, 1975; N. W. Katz, 1980; Whorwell, Prior, & Faragher, 1984; D. Spiegel, Bloom, Kraemer, & Gottheil, 1989; D. Spiegel, 1991). There is consequently a large body of research exploring specific uses of hypnotic phenomena in the treatment of somatic problems. Furthermore, the literature shows that for many disorders the outcome of hypnotic treatment is positively correlated with hypnotizability, the trait measure of an individual’s ability to enter a hypnotic state and carry out various hypnotic instructions for alteration in sensation, motor function, and memory (Hilgard, 1965; H. Spiegel & Spiegel, 1987). Hypnotizability is correlated about 0.5 with the effectiveness of hypnotic techniques in reducing pain (Hilgard & Hilgard, 1975) and is significantly associated with treatment outcome for migraine headache (Andreychuk & Skriver, 1975). Hypnotizability may also play a role in patient response to acupuncture (R. L. Katz, Kao, Spiegel, & Katz, 1974), and to training in self-hypnosis smoking control (D. Spiegel, Frischholz, Fleiss, & Spiegel, 1993). Note that some theorists contend that this relationship does not hold for all disorders (Barber, 1980; Erickson, 1967; Wadden & Anderton, 1982).

Our aim in this study was to examine whether individual differences in hypnotizability mediate responsiveness to dhumi-jhankri, an indigenous healing tradition in Nepal, which uses chanting, possession states, and animal sacrifices. In addition, we compared the hypnotizability scores of dhami-jhankri patients with those of Ayurvedic (an ancient Hindu healing art) and allopathic patients. By implication we can then assess whether the mutative component of dhami-jhankri healing may involve suggestive and cognitive processes similar to those involved with conventional Western uses of hypnosis in therapy. Until the 1950s, Nepal’s health care needs were met by a variety of traditional healers. These healers, such as Ayurvedic doctors (vaidyas), Tibetan medical practitioners, and Buddhist tantric healers, continue to thrive in Nepal, as does the largest group of traditional health practitioners, the dhami-jhankris. These dhami-jhankri healers, of whom there are an estimated 400,000 to 800,000 (Shrestha & Lediard, 1980), far outnumber allopathic medical personnel in Nepal. Their healing rituals typically involve chanting (tantra-mantra), herbs (jadibuti), possession states, drum beating, animal sacrifice, or some combination of the above (Hofer & Shrestha, 1973; Jones, 1976; Miller, 1979; Peters, 1981). Although in a strict biomedical model the efficacy of such practices may seem doubtful, it is clear that the dhami-jhankris enjoy the respect, trust, and belief of their patients.

Previous reports of shamans' or dhami-jhankris' use of hypnosis have been anecdotal and speculative (Azuma & Stevenson, 1988; Bergman, 1973; Edgerton, 1971). Examinations of altered states in dhami-jhankris'
practices have been largely limited to the healer’s own trance experience as a component of symbolic healing (Bourguignon, 1989; Heber, Fleisher, Ross, & Stanwick, 1989; Noll, 1989; Wautischer, 1989), rather than any direct effect on the patient. There are no systematic, quantitative studies evaluating the hypnotizability of such patients or studies examining the role suggestion or hypnosis-like features they might play in nonallopathic, indigenous healing traditions.

Hypnotizability, as measured in the West, is a stable and measurable trait (Hilgard, 1965; Piccione, Hilgard, & Zimbardo, 1989; H. Spiegel & Spiegel, 1987). It involves a capacity to focus attention; suspend peripheral awareness; dissociate various aspects of attention, memory, and consciousness; and respond to social cues (H. Spiegel & Spiegel, 1987). Furthermore, it has been shown that individuals who are higher in measured hypnotizability are more likely to engage in spontaneous cognitive shifts characterized in part by “absorption” (Tellegen, 1981; Tellegen & Atkinson, 1974). It follows then that an individual’s hypnotic capacity may be mobilized in many normal circumstances that do not explicitly involve hypnotic induction per se (H. Spiegel, 1974; H. Spiegel & Spiegel, 1987).

Several well-standardized and widely used scales of hypnotic responsiveness have been developed (H. Spiegel & Spiegel, 1987; Weitzenhoffer & Hilgard, 1959) in which a brief hypnotic induction is followed by various instructions to alter sensory experience, motor function, memory, or imagination. The degree of response to these suggestions is scored. If hypnotic potential is being tapped by a dhami-jhankri, the highly hypnotizable patient who has never been to such a practitioner might expect the dhami-jhankri to be more effective because the patient’s understanding of what goes on during a visit with the dhami-jhankri squares with his or her day-to-day experience of absorption and/or dissociation. Furthermore, when compared to low hypnotizables, highly hypnotizable patients might express greater satisfaction with these healers and might be more likely to return.

METHODS

Patients

The kingdom of Nepal is located between Tibet on its northern border and India on its southern one. Some demographic information and health-related statistics about Nepal are given in Table 1. The country is composed of a multitude of different ethnic groups speaking 26 different languages (Bista, 1987), and yet this diversity has produced a society highly tolerant of differences.

Kathmandu, the capital and largest city, reflects the diversity of Nepal, including its vast array of medical systems. There are several large allopathic hospitals, an Ayurvedic hospital, clinics of both types,
Table 1
Nepal - Demographics and Health Related Statistics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>21.8 million</td>
</tr>
<tr>
<td>Gross national product</td>
<td>31.1 billion</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>57 years at birth</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>79/1000 live births</td>
</tr>
<tr>
<td>Physician: patient ratio</td>
<td>1:23,000</td>
</tr>
<tr>
<td>Morbidity</td>
<td></td>
</tr>
<tr>
<td>Parasitic diseases</td>
<td>70-80% of population</td>
</tr>
<tr>
<td>Undernourishment</td>
<td>50% of children</td>
</tr>
<tr>
<td>Malnourishment</td>
<td>15% of children</td>
</tr>
</tbody>
</table>

and many dhami-jhankris. This situation presents the patient with a wide variety of treatment options. The decision to visit a particular type of healer may be based on various criteria, such as sociocultural bias, cost, or distance, but we hypothesize that the most obvious determinant is patient satisfaction with the healer. This provides a setting in which to examine differences in hypnotic potential between patient populations using different types of healers.

We interviewed patients at one dhami-jhankri's practice in Kathmandu. This healer, called Baje, is a 70-year-old dhami who has been practicing his healing (tantra-mantra) for about 50 years. He practices in a spare room in his apartment and in a storefront located over his home. Each day, from about 7 a.m., people gather and wait in the storefront for Baje to begin the day's work. Usually, he will see patients in his apartment until 8 or 8:30 a.m. and then come down to the store. It is not uncommon to see 20 or 30 people waiting for him by 8 a.m. His practice is largely pediatric; mothers and small children make up the bulk of those waiting and arriving during the course of the day. Adults also come to be treated, with men usually present only outside office hours. Baje sees patients on a first-come, first-served basis, and all payments are strictly voluntary. A total patient load of more than 50 people per day is not unusual.

Baje's treatment does not differ greatly from patient to patient, regardless of age, sex, or complaint. Usually there is no diagnostic phase, although he will sometimes begin by checking a pulse to determine whether or not a lagu, or pathological spirit, is present. Treatment consists of Baje continuously chanting a mantra, or song, while waving various objects around the patient, stroking the patient with these objects, and hitting the patient softly but firmly with a clump of straw resembling a small broom. In some cases, Baje may feed a thin brown liquid to the patient at the completion of the treatment. Occasionally, he will give
the patient a *jantra*-herbs in special paper tightly folded into a square, tied by a string, and worn around the neck.

The early morning practice, in a spare room of his apartment, is much less crowded and is regarded by some to be a better treatment, because there are fewer people and distractions, as one patient explained. Baje's actions, however, do not differ significantly. His mantra is a continuous, barely audible mumble. The entire episode lasts approximately 10 minutes per patient, during which most patients seem to be transfixed within the ritual.

Over the course of 2 months in 1992, we interviewed 248 male patients, all 16 years of age or older, 117 at Baje's clinic, 57 at the allopathic clinic, and 74 at the Ayurvedic clinic. Because the primary interviewer was male, it was felt that interviewing female patients would create an uncomfortable situation in this cultural context, and thus the study was limited to male patients. Given the complexity of applying our Western measures in a different culture, we also chose not to assess children in this study.

We compared Baje's patients with patients in allopathic and Ayurvedic settings. Ayurveda is a traditional medical system based on Hindu scripture utilizing herbal medicines and a holistic approach to treatment but seemingly does not use possession states, chanting, or unusual states of consciousness. We identified clinics that were similar to Baje's practice in terms of cost and distance. The general medicine outpatient clinics of Patan Hospital (allopathic) and Nardevi Hospital (Ayurvedic) fit these criteria well. Both charged only a nominal registration fee for services, although patients had to pay for medicines. Both were in the Kathmandu area and were located only a short distance from the dhami-jhankri.

**Materials**

Hypnotic capacity was assessed with the Hypnotic Induction Profile (HIP; H. Spiegel & Spiegel, 1987), which was translated into Nepali and modified for use in Nepal. Although the Nepali version of this instrument is as yet unnamed, psychometric properties of the HIP and its subscales have been thoroughly examined (H. Spiegel & Spiegel, 1987; Stern, Spiegel, & Nee, 1979). The Induction score is determined through responses to five items during a short induction. The five-item Induction score, measured on a scale of 1 to 10 in increments of 0.5, is internally reliable (Cronbach's alpha = .81) and shows good levels of test-retest reliability ($r = .81$ to .96 within a 3-week interval; $r = .76$ after a 3-year interval) (Stern et al., 1979). Studies have shown the Induction score to be correlated with the Stanford Hypnotic Susceptibility Scale, Form C (SHSS:C; Weitzenhoffer & Hilgard, 1962) in the range of .35 to .70 (Frischholz & Tryon, 1980; Frischholz et al., 1980; Orne et al., 1979).
The Eye-roll score, measured on a scale of 0 to 4 in increments of 0.5, measures the amount of sclera that can be observed while the subject simultaneously looks upward and closes his eyes. It is used as the hypnotic induction in the Hypnotic Induction Profile protocol (H. Spiegel & Spiegel, 1987) and is thought to measure biological potential for hypnosis (H. Spiegel, 1972, H. Spiegel & Spiegel, 1987). The rationale includes the fact that changes in eye movements are associated with other major changes in states of consciousness, such as sleep and dreaming. However, this claim has been contested (Hilgard, 1977), and no relationship between hypnotizability and this measure has been observed in some studies (Hilgard, 1982; Sheehan, Latta, Regina, & Smith, 1979). The Eye-roll score has been found to be moderately correlated with Tellegen's measure of absorption (Frischholz, Spiegel, Trentalange, & Spiegel, 1987) and predicts successful two-year smoking abstinence using self-hypnosis (D. Spiegel et al., 1993).

The Nepali version of the HIP was translated by the authors and subjected to a blind back-translation by bilingual Nepali and English speakers in both the United States and Nepal. The Induction score of the translated version was internally reliable (Cronbach's alpha = .74) at a level approaching the original English HIP (Cronbach's alpha = .81).

Procedures

Each patient was asked a series of demographic questions. Education was assessed on a scale from 1 to 9 (ranging from illiterate to education equivalent higher than a master's degree). Patients were then asked several questions about their current illness and past and present health-seeking behaviors. Based on the first 30 responses from the dhami-jhankri patients, we divided chief complaints into six categories: headache/dizziness, chest/abdominal pain, musculoskeletal pain, other pain, multiple pain, and other.

We proceeded to ask patients about the duration of illness, and whether they had been to an Ayurvedic doctor, an allopathic doctor, or a dhami-jhankri. We then asked whether the patient had ever been to a dhami-jhankri in the past and whether the patient had come to the interview site for some other illness in the past.

In the case of the dhami-jhankri's patients only, we asked subjects — after the treatment — to rate the healer's treatment as very good (dhere raamro), good (raamro), just acceptable (thikhai chha), bad (naraamro), or very bad (dhere naraamro).

Data Analysis

To analyze for differences in hypnotizability, a two-factor MANOVA was used with treatment groups and visit status as independent variables and Induction and Eye-roll scores as dependent variables. Where
necessary, this analysis was followed by an ANOVA and a posthoc analysis using the Scheffé method to localize the significance. Chi square analysis was used to examine differences among the treatment groups for chief complaint, and a one-way ANOVA was used to analyze for differences in age and literacy.

In the subset of the patients who saw the dhami-jhankri \( (n = 117) \), simple regression analysis was performed with the Induction Score as the independent and treatment satisfaction the dependent variable. An ANOVA was used to see if there was a difference in the two components of the hypnotizability score between first-time visitors and repeat visitors to the dhami-jhankri. An unpaired \( t \) test was used to analyze any difference in treatment satisfaction between first-time and repeat visitors.

**RESULTS**

The mean education level for the allopathic patients was 3.7 \( (SD = 2.1) \), 3.6 for the ayurvedic patients \( (SD = 2.0) \), and 2.8 for the dhami-jhankri patients \( (SD = 1.7) \) (2 representing literate but no schooling, 3 representing 1-5 years of school, and 4 representing 6-10 years of school). Thus, the dhami-jhankri’s patients were significantly less educated than either the allopathic patients or the Ayurvedic patients, \( F(2, 30) = 5.25, p < .01 \). There were no significant differences in age among the three different sites, \( F(2, 245) = 0.05, p = .951 \), or between first-time and repeat visitors to the dhami-jhankri, \( t(1, 100) = 1.94, p = .166 \). There were no significant differences with respect to chief complaint among the three treatment sites \( (x^2 = 13.38, df = 10, p = .203) \).

The means and standard deviations of the Induction and Eye-roll scores of the three treatment modalities are presented in Table 2. Only 2 patients were first-time visitors to the allopathic clinic. This required us to limit the analysis of visit status to dhami-jhankri and Ayurvedic patients. Thus, two analyses were carried out. The data regarding the three treatment modalities were analyzed in a one-factor MANOVA with treatment group as independent and Eye-roll and Induction scores as dependent variables. This analysis showed that there was an effect for treatment group \( (\text{Wilks's Lambda } F = 10.6, p < .01) \). Both components of the hypnotizability measure were significantly different among the three treatment groups, \( F(2, 245) = 11.3, p < .01 \) for the Induction score and \( F(2, 245) = 17.9, p < .01 \) for the Eye-roll score. A posthoc analysis using the Scheffé method showed that the Eye-roll score was significantly higher in the dhami-jhankri group than in both comparison groups \( (p < .01 \) for both groups), and this was also true for the Induction score \( (p < .01 \) for the allopathic group and \( p < .05 \) for the Ayurvedic group). There was no significant difference between the allopathic and Ayurvedic patients in their Induction \( (p = .113) \) or Eye-roll scores \( (p = .664) \). ANOVAs indicated that both components of the HIP for the 16
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Table 2
Means and Standard Deviation of Induction and Eye-roll Score for Three Patient Samples

<table>
<thead>
<tr>
<th>Hypnotizability</th>
<th>Allopathic (n = 57)</th>
<th>Ayurvedic (n = 74)</th>
<th>Faith Healer (n = 117)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index of</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Induction</td>
<td>5.25 (2.31)</td>
<td>6.01 (1.90)</td>
<td>6.80 (2.04)</td>
</tr>
<tr>
<td>Eye-roll</td>
<td>2.08 (1.16)</td>
<td>2.26 (1.24)</td>
<td>3.08 (1.00)</td>
</tr>
</tbody>
</table>

First-time dhami-jhankri patients examined did not differ significantly from allopathic or Ayurvedic patients, $F(2, 144) = 2.3, p = .104$ for the Induction score and $F(2, 144) = 0.7, p = .513$ for the Eye-roll score.

The allopathic patients were excluded from the second analysis, and a two-factor MANOVA, with treatment group and visit status as independent variables and Eye-roll score and Induction scores as dependent variables, was performed for the Ayurvedic and dhami-jhankri patients only. The results of this MANOVA showed that there was an effect for treatment group, Wilk's Lambda $F = 3.4, p < .05$, and visit status, Wilk's Lambda $F = 3.5, p < .05$, and a significant interaction between treatment group and visit status, Wilk's Lambda $F = 3.7, p < .05$. The posthoc analysis revealed that it was the repeat visitor dhami-jhankri patients who were significantly different from the first-time dhami-jhankri patients ($p < .01$ for Induction score and $p < .05$ for Eye-roll score) as well as from the first-time Ayurvedic patients ($p < .05$ for Induction score and $p < .01$ for Eye-roll score) and the repeat Ayurvedic patients ($p < .01$ both for Induction and Eye-roll scores). An additional analysis, in which we matched patient samples ($n = 57$) for age and chief complaint, yielded similar results for all statistics.

While age was negatively correlated with Eye-roll scores ($r = -.27, p < .001$), there was no significant correlation with the Induction score ($r = -.08, p = .189$). The Eye-roll score was positively correlated with education ($r = .20, p < .01$), but Induction score and education were not significantly correlated ($r = .05, p = .424$).
Characterization of dhami-jhankri patients is given in Table 3. Among the patients \((n = 117)\), treatment satisfaction was positively correlated with Induction \((r = .39, p < .001)\) and Eye-roll scores \((r = .26, p = .004)\). Repeat visitors were significantly more satisfied with the treatment than first-time visitors, \(t(1,100) = 4.57, p < .001\).

An informal comparison of the Induction scores of the Nepali samples to those of normal groups in Western studies (a group of 226 smokers, Frischholz, Spiegel, Spiegel, Balma, & Markell, 1982; and 83 normal volunteers, D. Spiegel, Detrick, & Frischholz, 1982) suggests that dhami-jhankri patients had similar Induction scores to the Western normals, but that the allopathic patients had lower scores.

**DISCUSSION**

We found higher hypnotic capacity among the dhami-jhankri’s patients than among patients from other medical sites. Hypnotizability of the dhami-jhankri patients was positively correlated with patients’ satisfaction with the treatment. Visit status was not related to hypnotizability in the Ayurvedic sample, but patients who returned to the dhami-jhankri were more hypnotizable than patients who were seeing him for the first time. In fact, first-time dhami-jhankri patients had hypnotizability scores quite similar to those of patients from the allopathic or Ayurvedic samples or groups. Unfortunately, no conclusions could be drawn from the allopathic sample because there were only 2 subjects in the first-time visit category. Thus, the overall effect of higher

### Table 3
**Dhami-Jhankri Patients** \((n = 117)\)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Percentages</th>
<th>Absolute Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic groups represented</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>Place of birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td>Village</td>
<td>79</td>
<td>92</td>
</tr>
<tr>
<td>Current home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kathmandu</td>
<td>77</td>
<td>90</td>
</tr>
<tr>
<td>Village</td>
<td>23</td>
<td>27</td>
</tr>
<tr>
<td>Literate</td>
<td>68</td>
<td>79(^a)</td>
</tr>
<tr>
<td>Repeat visitors</td>
<td>84</td>
<td>98(^b)</td>
</tr>
<tr>
<td>Past visits to other faith healer(s)</td>
<td>67</td>
<td>78(^b)</td>
</tr>
<tr>
<td>Health-seeking behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for current illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Had been to another faith healer</td>
<td>36</td>
<td>42</td>
</tr>
<tr>
<td>Had been to allopathic doctor</td>
<td>61</td>
<td>71</td>
</tr>
<tr>
<td>Baje is first resort</td>
<td>27</td>
<td>32</td>
</tr>
</tbody>
</table>

\(^a\) Literacy figures are self-reported and thus likely to be inflated.

\(^b\) Information unavailable from 15 patients.
hypnotizability was due to patients who returned to the dhami-jhankri for treatment. As might be expected, repeat visitors evaluated their treatment more positively than the first-time visitors.

Although these findings alone do not demonstrate the actual tapping of hypnotic potential by the dhami-jhankri, an inference of hypnosis as a vehicle for treatment could explain these results. Thus, the higher overall hypnotizability in dhami-jhankri patients is a reflection more of the type of person who returns for treatment. This indicates a selection process at the dhami-jhankri's practice that could be a result of hypnotic response mobilized by this healer to affect his treatment. The compelling nature of the experience with the dhami-jhankri, not necessarily the treatment's effectiveness, may lead patients to report high satisfaction and to return. It may be that highly hypnotizable subjects were more likely to have had an emotionally compelling experience, and thus be more satisfied. The interpretation of the data on satisfaction and the likelihood to return to treatment is limited because only the dhami-jhankri patients were assessed for their satisfaction with the treatment.

How can the differences in hypnotizability between dhami-jhankri patients and the other two sites be explained? We considered the possibility that preexisting patient demographic differences across the three sites could have explained the results quite apart from hypnotizability. We analyzed for differences in age, chief complaint, and literacy because these characteristics have been shown to be related to hypnotizability.

Like previous studies in the United States (H. Spiegel & Spiegel, 1987), we found age to be negatively correlated to the Eye-roll score. Age was, however, not significantly related to the Induction score, which differs from results in the U. S. literature. There were no significant differences in age among the three different sites or between the first-time and repeat visitors to the dhami-jhankri.

Another possible explanation is that the population seeking help from a dhami-jhankri suffered from different medical complaints. Among the 117 patients surveyed, 91.5% were seeking treatment for some type of pain, such as headaches, muscle aches, or stomachaches. A wealth of research documents the utility of hypnosis in controlling many types of pain (Hilgard & Hilgard, 1975; Lang, Joyce, Spiegel, Hamilton, & Lee, 1996; D. Spiegel & Bloom, 1983). It is possible that the dhami-jhankri uses hypnotic phenomena, while an allopathic doctor attends to the physiological problem and likely does not mobilize hypnotic ability. The high incidence of patients concurrently going to allopathic doctors suggests that patients may find ways to have both physical and psychological needs attended to. Such multiple-use patterns have been previously reported (Durkin-Longley, 1984; Eisenberg et al., 1993; Parker, 1988; Reissland & Burghart, 1989; Subedi, 1989). However, the analyses of the data did not demonstrate differences with respect to major complaint.
Because education has been shown to be positively correlated with HIP scores in the United States (H. Spiegel & Spiegel, 1987) and we did not control for educational level in our comparison groups, we checked for any hypnotizability differences based on educational differences. We found that the dhami-jhankri’s patients were significantly less educated than either the allopathic patients or Ayurvedic patients. One might then have expected dhami-jhankri patients to manifest lower hypnotizability scores. This was decidedly not the case.

Characteristics of Baje’s practice match other observations of urban healers in Nepal and elsewhere (Press, 1978; Skultans, 1988). These similarities indicate that it would be useful and interesting to conduct similar studies in areas where traditional healing enjoys popularity in an urban setting, even in the United States and other industrialized societies. We found relatively lower hypnotizability scores in the Nepali populations compared to samples in the United States. Thus, while we would expect the allopathic patients in Nepal to have a normal distribution and the dhami-jhankri patients to have higher scores, the general dampening effect results in the higher scores looking normal and the normal scores looking low. It was not possible to blind the examiner to the treatment condition, leaving the possibility that his expectation could have influenced the results. However, the fact that overall hypnotizability scores were equal to or lower than those of comparable samples in the United States at least indicates that this was not a highly suggestible sample that would be especially vulnerable to such expectancy biases in hypnotizability assessment.

Anthropologists and psychiatrists have previously speculated on the use of hypnosis by traditional rural dhami-jhankris either on themselves to go into trances or on their patients in an effort to heal (Edgerton, 1971; Hofer, 1973). In his extensive study of jhankris in Nepal, Miller (1979) expresses his belief that spirit-possession acts as an analgesic by allowing the patient to focus full attention on the pain and thereby control it. This fits well with Dow’s (1986) concept of symbolic healing in which the healer helps the patient particularize a general mythic world and manipulate healing symbols in it. It is easy to see how hypnosis can be used to focus attention and then manipulate symbols in order to relieve pain. This is particularly true in the rural setting, where the classical model of healer and patient having a closely shared worldview and time to affect the manipulation fits well. How this is accomplished in 10 minutes by the urban healer is more difficult to explain. Hypnotic pain relief through the short dhami-jhankri ceremony could explain the perceived benefit in the urban setting.

Understanding the actions and effects of dhami-jhankris is particularly critical in areas that are relatively underserved by Western medicine but widely served by dhami-jhankris. Given the fact that belief and participation in Western medicine results in a well-documented placebo
effect (Horwitz et al., 1990; Shapiro & Morris, 1978; Shea, 1991), it is reasonable to believe that this placebo effect may contribute to a perceived efficacy of other healing systems as well. Thus, methods of bioscientific medicine should serve to supplement rather than replace traditional dhami-jhankri healing. Indeed, it may even be a futile effort to attain such a replacement, because trust and belief in dhami-jhankris runs so deep (Parker, 1988; Rappaport & Rappaport, 1981). Supplemen
ting traditional healing, however, carries its own difficulties, primarily resistance by modern medical personnel (Dhakal, Graham-Jones, & Lockett, 1986; Green & Makhubu, 1984; Justice, 1984; Parker, 1988; Stone, 1986).

Efforts in Nepal to integrate modern medicine and traditional dhami-jhankri healing have been largely limited to training dhami-jhankris in allopathic concepts (Biswas & See, 1992) and this has often been unsuccessful due to lack of understanding of dhami-jhankris by modern medical personnel (Stone, 1986; Parker, 1988). A recent study shows that formal medical and health education among health care workers is negatively correlated with respect for dhami-jhankris (Biswas & See, 1992). If effective cooperation between modern and traditional systems is to be based on mutual respect and trust, all parties need to understand the practices and beliefs of each other’s systems. Although many have documented the enthusiasm of traditional healers to learn about modern medicine, most recognize that allopathic health professionals have difficulty understanding and accepting the practices of traditional healers (Green, 1988; Reissland & Burghart, 1989). If hypnosis can serve as a bridge between dhami-jhankri healing and an allopathic understanding of disease, a step may be taken toward increasing understanding of common treatment mechanisms underlying both dhami-jhankri healing and biomedical practice, as well as differences between the two. Given substantial public interest in alternative and complementary medical practice in the United States (Eisenberg et al., 1993), studies that define common ground and may enhance the rational use and efficacy of both Eastern and Western treatment systems are needed.

REFERENCES


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**Hypnotisierbarkeit und die Anwendung von traditioneller Dhami-Jhankri Heilkunde in Nepal**

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Hypnotisabilité et utilisation de la guérison traditionnelle Dhami-Jhankri au Népal

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Résumé: Ce travail a étudié le rôle de la sensibilité hypnotique dans la pratique du dhami-jhankri, approche de soins issue de la tradition népalaise. La capacité hypnotique de 248 patients masculins a été mesurée dans un cabinet médical allopathique occidental, dans un cabinet de médecine Ayurvédique (ancien art hindou de soins) et dans une pratique de dhami-jhankri. L’hypnotisabilité était établie au moyen du profil d’induction hypnotique (HIP). Les résultats d’induction du HIP étaient plus significativement plus élevés parmi les patients dhami-jhankri que parmi les Ayurvédiques ou allopathiques. En outre, les patients qui retournerent à l’approche dhami-jhankri étaient plus fortement hypnotisables que ceux qui y étaient allés pour la première fois. De plus, la satisfaction des patients soumis au traitement dhami-jhankri était corrélée positivement aux scores HIP. Les auteurs ont conclu que le phénomène hypnotique, tel qu’il est mesuré en Occident, doit être un des composants importants du traitement dhami-jhankri en Orient.

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La hipnotizabilidad y el uso de la curación tradicional Dhami-Jhankri en el Nepal

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Resumen: Este estudio examinó el papel de la responsividad hipnótica en la práctica de un dhami-jhankri, un curandero tradicional Nepalés. Se midió la capacidad hipnótica de 248 pacientes varones en una clínica alopathique (Occidental), una clínica Ayurvédica (antigua arte de curación Hindú), y en la práctica de un dhami-jhankri. Se evaluó la hipnotizabilidad con el Perfil de Inducción Hipnótica (Hypnotic Induction Profile o HIP). Las puntuaciones de inducción del HIP entre los pacientes del dhami-jhankri fueron significativamente más altas que entre los pacientes Ayurvédicos o alopathicos. Asimismo, el grupo de pacientes que habían tenido una consulta anterior con el dhami-jhankri eran más altamente hipnotizables que quienes asistían a la primera consulta. La satisfacción con el tratamiento entre los pacientes del dhami-jhankri estuvo correlacionada positivamente con las puntuaciones del HIP. Los autores concluyen que los fenómenos hipnóticos tal como se miden en el Occidente pueden ser un componente importante del tratamiento del dhami-jhankri en el Oriente.

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