

# AUSTRALIAN JOURNAL OF CLINICAL AND EXPERIMENTAL HYPNOSIS

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CLINICAL AND EXPERIMENTAL HYPNOSIS

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## EDITOR'S NOTE

This edition of the *Australian Journal of Clinical and Experimental Hypnosis* heralds a new era, with the change in editorship from Dr Wendy-Louise Walker.

Wendy-Louise Walker has served the Australian Society of Hypnosis in many ways, not the least of which has been as editor of our journal over many years. As editor for just one edition, I am becoming aware of the countless hours of service she has rendered the membership of the Society in producing what has been a journal with national and international recognition of its quality and scope. Wendy-Louise Walker deserves the thanks and congratulations of every member of the Society. It will be my privilege to work with her in her new role as President-Elect of ASH for the period 1993-95 and then as President in 1995-97.

As editor, I hope that I can maintain the standard set by Wendy-Louise Walker. I will try to satisfy all members of the Society, by publishing a range of papers dealing with research, experimental and clinical issues in hypnosis. Each edition will feature both peer-reviewed manuscripts and case histories submitted by candidates for Full Membership of the Society, which have been highly rated by examiners of the Board of Education. Together with their interest to readers of the journal, I believe that publication of case histories is one way the Society and Board of Education have of recognising the effort and commitment of examination candidates.

I call upon the readers of our journal to show their support by submitting manuscripts for peer review and case descriptions of hypnosis in clinical practice. Ultimately the success of our journal will reflect the interest, commitment, and involvement of its readers.

This edition contains a number of invited manuscripts, from local and international experts in different areas of hypnosis. Peter Bloom, MD, President-Elect of the International Society of Hypnosis, describes how he attempts to integrate so-called "traditional" approaches to hypnosis with Ericksonian approaches, to achieve greater insight and effectiveness in psychotherapy. In their paper, David Spiegel, MD, President-Elect of the Society for Clinical and Experimental Hypnosis, and his colleagues, describe the rationale for the alterations made to the personality disorders classification in DSM IV and the inclusion of a new category Acute Stress Disorder, distinguished from Post-traumatic Stress Disorder. Alan Schefflin, JD, LL.M., Professor of Law at Santa Clara University, California, and author of *Trance on Trial*, reviews issues in forensic hypnosis and the law, and adroitly challenges the position taken by U.S. courts on the admissibility of hypnotically elicited evidence.

Two Australian academics noted for their work in hypnosis have also contributed invited manuscripts to this edition. Professor Peter Sheehan, Pro-Vice Chancellor of the University of Queensland, and his colleague describe experimental work, aimed at clarifying the relationship between interrogative

suggestibility and susceptibility to hypnosis. Their work suggests that these two dimensions are related, an important finding for clinical and forensic work involving hypnosis. The new President of the Australian Society of Hypnosis, Robb Stanley, has contributed a review of hypnosis legislation in Australia.

This volume concludes with three detailed and interesting case histories involving hypnosis, submitted by Full Members of the Society. Graham Scott reports the use of hypnosis in the treatment of a dental phobia and Simon Stafrace details his use of hypnosis as an important adjunct with pharmacotherapy and cognitive-behaviour therapy in the treatment of panic disorder with agoraphobia. Judith Leung reports the use of hypnosis in the treatment of post-traumatic stress disorder, following a car accident.

I recommend these invited papers and case histories for their interest, analysis and contribution to our professional practice of hypnosis.

*Barry J. Evans  
Monash University  
May 1994*

## **HOW DOES A NON-ERICKSONIAN INTEGRATE ERICKSONIAN TECHNIQUES WITHOUT BECOMING AN ERICKSONIAN?**

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As creative therapists, we work by fusing the scientific underpinnings of our disciplines with our intuitive understanding derived from our clinical experiences. As we mature, we find our own voice as a therapist. Ericksonian techniques in trance induction and therapy are rich in nuance and complexity. Many therapists have hesitated to integrate Milton Erickson's work into their practices in fear that they might have to abandon the style and colouring of their own developing therapeutic posture. This paper examines a variety of Ericksonian techniques and compares them with some examples of my own work over the years. I conclude that these techniques are easily identified and adapted to a variety of clinical approaches and that abundant opportunities exist for Ericksonians and non-Ericksonians to learn from each others' work.

Early in my training in internal medicine, before becoming a psychiatrist, I developed a strong interest in the doctor/patient relationship. I became intrigued with how to maximise bedside manner, how to create a therapeutic alliance, and how to understand common sense in these matters. My teachers had said, "One deals with patients by just following common sense." While I had such a sense, it seemed to be of a different kind and far from common when compared with the sense of some of my colleagues working with the psychological aspects of medicine. In those early years, moving from my residency in internal medicine to my residency in psychiatry, I continued to experiment with a variety of approaches to patient care which felt natural and were centred on my own developing ideas of how therapy works.

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An earlier version of this Keynote Address will appear in *The Proceedings of The International Symposium on Direct and Indirect Techniques in Hypnosis and Psychotherapy*. Rome, Italy, 1991.

Requests for reprints should be sent to Peter B. Bloom MD, 111 49th Street, Philadelphia, PA 19139, U.S.A.

In the United States (and possibly Australia) many psychiatrists are leaning more and more toward the biological basis of medical psychiatry. We risk failing to teach our resident psychiatrists how to do psychotherapy. It was with great interest and enthusiasm, then, that I met with a group of psychiatrists, psychologists and other interested professionals to talk about creative therapy at an Ericksonian symposium, during the 5th European Congress in 1990 in Constance, Germany. In recent years, I have been watching the Ericksonian Foundation spreading the name of Milton H. Erickson around the world and so I wanted to gain, first hand, an impression of Ericksonian hypnosis because I was unsure of its relationship to Erickson's own work, with which I was quite familiar (Haley, 1967, 1973). I was surprised. This was a symposium not so much on hypnotic techniques, per se, as I had expected, but rather it was a creative discussion on clinical methods of psychotherapy. I was pleased because I had not been able to account for the immense popularity of the Ericksonian movement if it were, as I had believed, just based on popularising Erickson's and his followers' own hypnotic techniques. It occurred to me, following this workshop, that the popularity of the Ericksonian movement was based primarily on offering a way of looking at and enhancing psychotherapy.

If this is so, why are "Ericksonian" and "non-Ericksonian" or "traditional" hypnotherapists at apparent odds with each other, seeming to describe different therapeutic strategies when both groups emphasise the value of psychotherapy?<sup>1</sup>

My interest in these issues peaked when I recently reviewed Michael D. Yapko's book entitled *Trancework: An Introduction to the Practice of Clinical Hypnosis* (2nd ed.), 1990. As I read his description of Ericksonian techniques and Yapko's own effective methods of psychotherapy, it occurred to me that the apparent differences between non-Ericksonian hypnosis and Ericksonian hypnosis become less obvious when perceived from the common ground of effective psychotherapy. Nonetheless, it continued to trouble me that the seemingly idiosyncratic Ericksonian nomenclature, which labels universal hypnotic techniques, is peculiarly distancing to me. It seems the Ericksonians are suggesting that we are talking about different things when I believe we are not (Bloom, 1991). The real danger, I believe, is that traditional hypnotherapists will not be willing to learn from Ericksonian hypnotherapists because of their perception that one must embrace an ideology, a school of hypnosis, and a radically unfamiliar frame of reference regarding psychotherapy. In the remainder of this paper, I hope I can argue the point that, in all our creative work we are at our best when we use both Ericksonian and traditional approaches to hypnosis and psychotherapy.

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<sup>1</sup> Since 1979 when the term Ericksonian was first used in print in conjunction with the International Congress on Approaches to Hypnosis and Psychotherapy (Zeig, personal communication, 1991), the terms "non-Ericksonian" or "traditional" have been used to describe those unfamiliar or unidentified with Erickson's own approach to hypnosis and psychotherapy. I use either term interchangeably, although I recognise the inherent restrictions such labels may present for therapists wishing to develop their own creative styles.

I shall present four of my early cases which I believe integrate therapeutic strategies from both the traditional and Ericksonian point of view. I shall argue that the clinical methods are similar to both groups despite the seeming differences in terminology. If they are similar, as I believe them to be, what conclusions can we reach in sharing our work more comfortably about the true nature of psychotherapy?

I shall present my cases under several headings. In each heading, the hypnotic techniques associated with traditional hypnosis will precede the hypnotic technique associated with Ericksonian hypnosis. It is my hope that these cases will illustrate the effectiveness of hypnosis and psychotherapy which is dependent more on the unique therapeutic needs of the patient than on the differences in terminology. I believe non-Ericksonians and Ericksonians alike can learn from each other to be more effective therapists without regard to the various ways each has of describing the process of therapy.

## **CASE PRESENTATIONS**

### **Paradoxical Intention and/or Negative Suggestion**

Paradoxical intention usually involves telling a patient to continue a behaviour he or she is already doing in order to extinguish it. Negative suggestion involves telling a patient not to respond in a desired way in order to elicit the desired behaviour (Yapko, 1990, p. 163). Indirect suggestions, currently popular within the Ericksonian movement, are by no means the only effective way to deliver a therapeutic message to our patients. Equally elegant and powerful in their effects are direct suggestions such as paradoxical intention or negative suggestions. When a patient is confronted with a direct request to continue to do what he or she is already doing or to not respond in a desired way, such as trying to stay out of trance in order to go into one, he or she usually responds by stopping the behaviour and adopting a more adaptive behaviour to meet his or her primary needs. No one likes to be controlled and one is often willing to recover emotionally in order to remain in control of one's thoughts, mood, and behaviours. Thus, when used clinically, paradoxical intention or its related term negative suggestion, can be a powerful therapeutic modality. I will describe this process as I used it with one of my daughters and then with one of my patients.

When aged three my daughter was pounding her spoon on her dinner dish and screaming loudly while sitting with the family at the dining room table. Wishing to intervene for all our sakes, I smiled and said, "Diana, scream again, louder". She looked at me for a moment, and proceeded to scream and hit her plate with her spoon, but not quite as loud this time. When she caught her breath, I said, "Diana, scream again, louder!" She looked at me once more, and started to get down out of her high chair while screaming again less loudly. We repeated this exchange a few more times until she had slowly made her way over to me and was cuddling in my arms whispering

a little scream. The results were clear. She got what she wanted, which was more close attention from me, and I got what I wanted, some relief from her screaming at dinner!

Paradoxical intention seldom, if ever, drives people to actually continue what they are already doing to their detriment. Most patients do not follow the commands literally, nor do patients paradoxically do the opposite of what they are now doing with no more personal or psychological involvement. What this intervention does do is to directly force the patient to face the issue of control and power, so that he or she finds it necessary to adopt a more adaptive means of coping with the actual need expressed within the behaviour. My daughter perceived that a better adaptation to her screaming for attention would be to directly ask for the attention she wanted by coming to me for it. Whether it be called paradoxical intention or negative suggestion, this kind of “reverse psychology” – asking for more of the same behaviour in order to extinguish it and to create the opportunity for more adaptive behaviour – is a powerful tool and, incidentally, has been used by most successful mothers throughout the ages.

Another example of this kind of direct suggestion comes from my practice. I treated a young woman who weighed 180 pounds. She was single and beginning graduate school. When she came to my office, she said she felt like a “green-headed monster,” a term representing her low self-esteem. We began psychotherapy and, soon, turned our attention to her excess weight which she felt prevented her socialising with men. After six months of psychotherapy with no resulting weight loss, I was preparing to go on a long Christmas holiday. During our last session, I looked at her and I said, “I am going to finish therapy with you, unless, when I return from vacation, you have gained 20 more pounds and weigh 200 pounds. This new weight of 200 pounds will be my criterion for our continuing psychotherapy. If you will not lose, I insist you gain weight to demonstrate your ability to change.” We looked at each other and, of course, talked it through thoroughly. The therapeutic alliance remained strong and, despite this very direct and demanding confrontation, a constructive sense of mutual collaboration was maintained. Nonetheless, it was serious therapeutic business. I was firm and I meant what I had said, and she knew it.

Was actual hypnosis involved? Lately, I am becoming less clear about when hypnosis is utilised and when it is not. I have thought for a long time that in all our psychotherapy, we use hypnotic techniques whether the patient is in or out of trance to help us through certain kinds of impasse. I suggest that this kind of direct suggestion has applications throughout our work. In any event, I went out of town on vacation.

Today, I am sure I would never use the direct suggestion of paradoxical intention with a patient just before I was leaving town and thereby being unavailable to her. I did leave, though, and when I returned she was grotesque. She had acne on her face, she was swollen, and she weighed 198 pounds.



She told me she had weighed 200 pounds two days before my return and she had become so upset she felt it imperative to lose weight. Even so, at 198 pounds, she could barely sit in my office chair. As she looked at me, she said she would never, never weigh that much again in her life. She then began to work in psychotherapy in earnest. It was a fascinating experience for me. I suppose I had not been fully aware of the risks that I had imposed on her, but as therapists, we do risk: We risk ourselves, we risk our patients. One hopes these risks are in the service of the patient's care and not in the service of our own ego.

Four months later she weighed 135 pounds. Now thinner, she "discovered" across the hallway in her apartment house a young man who had lived there for the past two years. He began talking to her, invited her for dinner, and married her a year later. They have a child and my patient practises social work in another city today. This intervention was the turning point of our therapy: a direct suggestion to gain weight, not just a simple suggestion, but a complex one involving paradoxical intention utilised within the context of a strong therapeutic alliance. I do not ever recommend taking a technique that works in the unique individual context of one patient and applying it to all patients. Suggesting weight gain is not a generic technique for weight loss programs. But in some patients for specific reasons inherent in their psychotherapy, both non-Ericksonians and Ericksonians have techniques that can be enormously effective in working through therapeutic impasses.

### **Reorienting a Patient with Additional, Usually Positive Options and/or Reframing**

Reframing is an Ericksonian word for, I believe, nothing more and nothing less than reorienting a patient with positive options. However, things are not always as they seem. In reorienting or reframing, entirely new perspectives on living can evolve.

### **Telling Stories and/or Using Metaphors**

Telling stories or using metaphors that have meaning for patients is another powerful psychotherapeutic intervention that is enhanced in hypnosis. Both non-Ericksonian and Ericksonian therapists tell stories that have meaning and speak directly or symbolically to patients' problems. I am concerned when Ericksonians call stories metaphors, thereby creating different labels. Two labels describing the same process can create difficulties in communicating our experiences with one another because it may be assumed by some that we are describing different phenomena.

### **Patient or Client Centred and/or Naturalistic Approaches; Accepting Responses, Behaviours and Resistances as Cooperation and/or Utilisation**

These two techniques described by both non-Ericksonians and Ericksonians were used in the next case. A naturalistic approach involves taking cognisance

of a patient as he or she presents, an idea Carl Rogers called client centred therapy (1951). The Ericksonian term of utilisation refers to resolving resistance to therapy by defining the patient's response and behaviour as cooperation. To illustrate the use of these universal hypnotic techniques in the course of psychotherapy, I would like to present another case from my early practice.

I saw a 52-year-old black male accountant in hospital consultation after his third heart attack. The first heart attack had almost cost him his life. His second heart attack had left him with hiccups but he eventually recovered and reported taking his medications by the stopwatch during the day. He was an accountant who kept track of all the financial records at our local Veterans' Administration Hospital in Philadelphia. He was always on time and felt in complete control of his life. However, despite his sense of mastery and control, he suffered his third and current heart attack. Once again, he presented with intractable hiccups so severe that his physicians were considering surgically crushing his phrenic nerves in order to paralyse his diaphragm to prevent his hiccups, as everything else they had tried had been ineffective. Two days before his scheduled surgery, he asked for a trial of hypnosis.

When I went to see him, he told me he did not believe in hypnosis, but had asked for my consultation in order to delay and perhaps avoid the surgery. When I asked him what he did believe in, he said, "The only thing I believe in is my accounting skill and my ability to control my life with discipline." In the consulting room just off the medical floor, I was joined by several residents in medicine waiting to see me use hypnosis with this patient. I felt awkward having to explain the challenge now presented to me.

In utilising the patient's responses and behaviours while remaining aware of his resistances, I elected to alter my interventions accordingly. Keeping in mind his strengths and assets, I asked him if he were truly good at keeping records and he said he was, of course. I asked the medical resident to obtain a stopwatch from the haematology department, and I requested the patient to write down every single hiccup he had during the day. He explained to me he had "singles" (which would be one hiccup), "doubles" (which would be two at a time), and occasionally "triples." I asked him to record with the stopwatch each and every hiccup he had during the day: singles, doubles, and triples. I looked him in the eye and with a slow steady hypnotic voice, I said, "and at the end of the day, *when you are finished* [emphasis mine], I would like you to add up all the time you have recorded that you have spent hiccupping: all the singles, the doubles, and the triples." He looked at me absorbed in the process and nodded his agreement. I told him I would return in two days to look at his record of his hiccup experience.

I had learnt from interviewing the hospital personnel caring for the patient that his hiccups stopped whenever a nurse patted him on his back or shoulder. I also had learnt that he did not hiccup at night while sleeping, thus supporting my sense that this symptom was a plea for attention, not solely a presentation of the damaged heart muscle irritating the adjacent phrenic nerve. When one

empathises with this patient, his stress is easily understood: having three heart attacks despite following his physician's orders impeccably, and then learning he may have to undergo bilateral phrenic nerve crushes. Anyone would require attention and support but this man could not ask for it directly. His need for attention was my working dynamic and provided the rationale for my intervention.

Two days later, I returned to his room to see how he was doing. I asked him how he had recorded his hiccups with the stopwatch and he replied that he had not used it. I asked to see his graph of his recorded hiccups and he showed it to me. It had only one entry: "Tried one more time with the nasogastric tube to tickle the back of my throat, hiccups stopped." He had recovered from his hiccups, avoided surgery, and avoided the onerous recording task I had given him. Was it a fortuitous last attempt with the previously prescribed therapy or was it related to my own intervention?

How might we understand his response? To the very end, he resisted our interaction. However, he knew psychologically from the moment I left his room on the first day that every future hiccup would be in "my presence"; that is, I would see the record in two days and review every recorded hiccup. Thus, he could imagine I would be with him all the time, lending my interest and support. My response to his need for attention would be nearly absolute. To maintain control over his freedom from recording his hiccups, his only solution was to give up the hiccups. Certainly, this was easier than the act and work of recording each and every hiccup I had required of him. Most importantly, the hypnotic/behavioural message was clearly given in the phrase "at the end of the day when you are finished hiccupping." It was a powerful suggestion given this particular man in this naturalistic approach utilising his every response to my intervention.

In the final analysis, patients utilise many resources offered them in critical times. The immediacy of surgery, the behavioural paradigm recognising his need for attention, his disbelief in hypnosis, and the continued availability of the nasogastric tube all played a role. I believe, however, it was the psychological/behavioural/hypnotic intervention that tipped the scale towards recovery in this patient.

### **The Message within the Message, or Meta-Message and/or Embedded Messages**

Human communication occurs on many levels. An interesting exercise in teaching hypnosis to professionals is to encourage practising inductions without saying a word. Quickly, participants learn to better use breathing, body movements and expressions to convey hypnotic intentions to their subjects. Communication among family members often contains embedded messages that create great difficulty for our patients, requiring our interventions to promote healing. Treatment in these cases can also rely on using complex messages within the usual therapeutic interactions to promote a return to

health. Let us examine another case in which “traditionalists” and “Ericksonians” would find common ground in understanding the presenting problem and choosing the treatment paradigm.

I saw an electrician who reported driving to another city to see his mother who had suffered a stroke. After observing how ill she was and consulting with her doctors, he immediately sold her home and made a reservation for her in a long-term nursing home. Unexpectedly, she partially recovered, and when he came back to visit her, he told her what he had done. She said, “Can’t you *see* what you’ve done?” Of course, in English, the word “see” also means “understand”. Following this confrontation with his mother, feeling increasingly guilty for what he had done, he began to drive home from his mother’s hospital to his own city many miles away. En route, the lights of the oncoming cars began to “break up,” he experienced tunnel vision, and by the time he arrived at his home he was hysterically blind. Shortly thereafter, he was admitted to our psychiatric hospital. First, his eyes were examined by a qualified ophthalmologist who found them normal. Then, we turned our attention to his mother’s statement, “Can’t you *see* what you have done?” The message within the message or the embedded message is always a challenge and of interest to tease out. Treatment was designed to reverse the development of his psychosomatic presentation by symbolically treating his eyesight and helping him integrate his mother’s new physical status. We began by preparing some very warm saline soaks. I put them on his eyes and held them there for about 20 minutes. Later that day, the nurse followed my example and told him that, gradually, with these warm saline soaks, he would be able to regain his vision. Simultaneously, I began talking with him about how reasonable his actions had been in putting his mother into the nursing home. On integrating this insight and in response to our ministrations, he recovered both his vision and his composure and went home. Messages within messages: One doesn’t need to be a “traditionalist” or an “Ericksonian” to utilise these techniques that are common to all effective therapy no matter what the particular persuasion of the therapist.

### **Accepting Responses, Behaviours, and Resistances as Cooperation and/or Utilisation**

I was asked to see a young woman who heard her mother’s voice saying “No” each time she tried to consummate her sexual relationship with her fiancé. While this was her only hallucination, she was in her third engagement. As a strict Roman Catholic, she was ambivalent about sex before marriage, but was eager to resolve this difficulty before her wedding.

During the third month of therapy, she began her session saying, “Two men at work have asked me to go to bed with them.” As she was sitting down, I turned away from her chair and “imagined” I saw a ticker tape machine (those machines which have a thin strip of paper coming out allowing one to read the news or the stock market reports). I “reached” for the pretend

tape noting she was in trance and was staring at it too. As I “pulled” it out, I “read,” “the United States Public Health Service has warned all young women not to sleep with these two men because they have contracted the most severe case of syphilis ever reported.” After continuing to note her full absorption and involvement in this spontaneous process, I “took” the tape in my hand, while she continued to stare at it in trance. I then “reached” for a pair of scissors and cut the ticker tape. As I held it towards her, she spontaneously opened her purse, I dropped it in and she closed the purse.

When we do this kind of spontaneous work, when we follow our own creative impulse, we should constantly check, in secondary process, to see if it fits the context of the overall therapy. My plea is to encourage us not to block these moments of creativity, but to see if what transpires seems right for that particular patient at that particular moment and that the process of therapy seems to flow by this intervention.

Two minutes of therapy had elapsed and we had 58 minutes left in the hour. I decided not to discuss this interaction. We talked about the Christmas holidays and how, as an airline stewardess, she could fly at no cost from Philadelphia to Dallas to do her shopping. We managed to get through the therapy hour without referencing this earlier therapeutic interaction. As she got to the door, she turned, patted her purse, and looked at me and said, “Thank you.”

The shared image of the ticker tape was a symbol for saying “No”: a symbol she accepted and received in her purse. Once she had the inner resources to freely say “No” herself to the men at work, she could tap the same resources freely to say the more desired “Yes” to her fiancé. Over the next several weeks, her mother’s hallucinated voice began to recede, then finally disappeared. My patient began an emotional and physically balanced relationship with her current fiancé. They were married six months later and my wife and I danced at their wedding. In a long-term follow up, twelve years later, she called to ask for a referral to a good paediatrician for her children. I asked if she remembered the session when she was in my office involving the ticker tape. She said she did not remember much of anything that we did, but felt much better and thanked me. It seems the patients with whom we are most successful will not be able to describe their therapy in detail. Often, there are no remembered techniques, only the awareness of intensely shared experiences that helped (Bloom, 1989, 1990).

## **CONCLUSION**

These examples from my early practice highlight the power and complexity of direct suggestion, of indirect suggestion and the use of a shared imagery and shared trance. Therapy is based on the use of observation and the freedom to be creative with each patient, irrespective of technique. During a visit with Milton Erickson in 1972, I asked him for the one word he would suggest that I remember for my lifetime in order to enhance my ongoing growth

as a psychiatrist. Erickson immediately replied, "*Observation.*" He said, "*If you observe your patients and yourself, you will have all the data you will ever need.*"

It is my opinion that the new Ericksonian labels describing the various interventions of psychotherapy have little to do with real differences, but constructively serve to organise certain kinds of thinking for some clinicians about how therapy works. "How a non-Ericksonian therapist can use Ericksonian techniques without becoming an Ericksonian" contains a deep admonition that none of us should become traditionalists and none of us should become Ericksonians. We do and can learn from our own feelings and insight what therapy is, based always on the context of our rigorous training. When training and intuition fuse, my understanding of how to do therapy becomes "just opening my mouth and letting it come out" (Bloom, 1989, 1990).

I encourage each of you to have the freedom from doctrine to be yourself and to learn directly from your patients. Ericksonian techniques are useful. We should learn from them and adopt those that fit our style. We should do this, not in the service of becoming an Ericksonian or in the belief in Erickson's special importance, but in the ever-evolving free application of our knowledge and art in the service of each patient who seeks our care.

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## **ACUTE STRESS DISORDER AND DISSOCIATION**

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Trauma is a sudden discontinuity in experience which frequently induces dissociative as well as anxiety states. Until recently there has been little attention paid to acute symptomatology which arises during and immediately after traumatic stress. However, manifestations of this pattern of response to trauma have been described in a new diagnostic category to be included in the DSM IV, Acute Stress Disorder, which includes dissociative as well as anxiety, re-experiencing, and avoidance symptoms. Severe acute dissociative symptoms predict later post-traumatic stress disorder (PTSD), indicating the importance of acute dissociative symptoms in the development of chronic symptoms following trauma and may also be related to the development of other dissociative disorders. Related changes in the dissociative disorders section of the DSM IV will be described, including the name change from multiple personality disorder to dissociative identity disorder. Treatment for post-traumatic dissociative symptoms emphasises helping the survivor to develop, acknowledge, bear and restructure traumatic memories by integrating the trauma into a meaningful and less self-blaming perspective and to mobilise and strengthen supportive interpersonal relationships.

### **TRAUMA AND DISSOCIATION**

It is well known that traumatic experiences trigger the onset of intense emotions and exert a disintegrating effect on the mind. The concept of "psychic trauma" was first introduced by Albert Eulenberg in 1878 (Van der Hart & Brown, 1990), and with each World War, this concept was resurrected, with "shell

shock" in World War I and "traumatic neurosis" in World War II (Kardiner & Spiegel, 1947). In the psychiatric literature, it is well accepted that when a traumatic event occurs, the development of depressive and anxiety symptoms follow in a substantial minority of victims. Another consequence of trauma that is often overlooked but may well be just as important is the development of dissociative symptoms, fostering avoidance of a fully integrated awareness and working through of the traumatic event. Anxiety has served such an influential role in the prevailing understanding of the impact of trauma that post-traumatic stress disorder is classified as an anxiety disorder in the DSM III-R, despite the inclusion of dissociative symptoms such as amnesia and numbing (Spiegel, 1991a).

Dissociation, as defined in the DSM IV (American Psychiatric Association [APA], 1993), is a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. Events which would ordinarily be connected are divided from one another via barriers of amnesia and discontinuities in attention (Hilgard, 1977; Spiegel, 1991b). Dissociating from a traumatic event while it occurs is thought to be a defence against the overwhelming fear, pain, or helplessness it engenders (Spiegel, 1991b). Dissociation in response to trauma takes forms that are likely to vary in response to the varieties of trauma. Dissociative states may be common in the general population (Ross, Joshi, & Currie, 1991), as is trauma (Ropp, Visintainer, Uman, & Treloar, 1992). Furthermore, there is a growing literature suggesting that many dissociative disorders are chronic post-traumatic stress disorders (Kluft, 1985; Spiegel, 1984; Terr, 1991). If this is so, one should be able to observe dissociative symptoms in the immediate aftermath of traumatic stress. Here we describe the pattern of dissociative symptoms arising in response to trauma which led to the inclusion of the Acute Stress Disorder category in the DSM IV.

## **TRAUMATIC STRESS**

Trauma is an abrupt physical disruption in one's ordinary daily experience and involves actual or threatened injury or death to oneself or to others. It elicits reactions of intense horror, fear, or helplessness. Examples of trauma include bushfires and other natural disasters, violent crimes, and war. The very unpredictability of the physical stress makes it adaptive to buffer this traumatic input by distorting, altering, or avoiding its impact. However, such defences may inhibit the subsequent working through of trauma, sometimes referred to as "grief work" (Lindemann, 1944), thereby hampering rehabilitation and leaving the individual with an experience of self as damaged or fragmented (Spiegel, 1986).

Traumas differ in terms of severity and there are both subjective and objective components. Post-traumatic stress disorders have been diagnosed in as many as 33% of Vietnam combat veterans in one study although this is probably



a high estimate of overall prevalence (Keane, Caddell & Taylor, 1988). The subjective severity of the trauma is likely to be influenced by the meaning that is attached to it. Predictors of worse outcome include a history of prior traumatisation (Coons & Milstein, 1986; Putnam, Guroff, Silberman, Barban, & Post, 1986; Terr, 1991), a tendency to take excessive responsibility for causing or being injured by the trauma (Solomon, Regier, & Burke, 1989) and feeling emotionally numb (Lindemann, 1944; Solomon, Mikulincer, & Benbenisty, 1989).

## **DISSOCIATIVE AND OTHER SYMPTOMS IN RESPONSE TO TRAUMA**

Four broad categories of response emerge during a traumatic experience: dissociative symptoms, anxiety, intrusive recollection and avoidance (Classen, Koopman & Spiegel, 1993). If these symptoms are no more than moderately intense and transient, they may be a normal response to an abnormally traumatic situation. However, in their more severe and lasting forms, they may constitute a disorder.

### **Dissociative Symptoms**

Dissociative responses to trauma include depersonalisation, derealisation, stupor, numbing and amnesia for the traumatic event (Classen et al., 1993). Depersonalisation is an altered sense of connection to oneself or to one's body, illustrated by the 25% of our sample of persons who had experienced the 1989 San Francisco Bay area earthquake who reported feeling detached from their bodies in the aftermath of the tremor (Cardena & Spiegel, 1993). Derealisation is an altered sense of reality beyond oneself, as illustrated in a car passenger's account of an accident in which the car was nearly hit by a train. The passenger recalled that: "as the train went by I saw the engineer's face. It was like a movie run slowly so the frames progress with a jerky motion" (Noyes & Kletti, 1977, p. 377). Numbing of emotional responsiveness is a common dissociative response, reported by 54% of survivors of a plane crash (Sloan, 1988). Stupor, or a lack of awareness of one's environment, is another type of dissociation that is illustrated by a kidnapped woman who reported that she became unaware of the ropes that bound her legs and arms (Siegel, 1984, p. 267). Amnesia for the traumatic event may be partial or total, as shown by two children who survived a lightning strike, both of whom had no memory for the incident (Dollinger, 1985).

### **Anxiety/Hyperarousal Symptoms**

Anxiety or hyperarousal symptoms are another frequent psychological response to trauma. In a study of Namibia ambush survivors, 13 of 14 reported having symptoms of hyperarousal or an exaggerated startle response one week later (Feinstein, 1989). Similarly, in our study of earthquake survivors, 67% reported hypervigilance a week later and for 29% of the sample this continued at 4 months (Cardena & Spiegel, 1993).

### **Intrusive Recollections of the Trauma**

Intrusive recollections of the trauma include both unwarranted recall of memories of the traumatic event and also reliving the traumatic event. Intrusive recollections are likely to be associated with the intensity of contact with the trauma: Repeated recollections of the collapse of the Hyatt Regency Hotel skywalks were most often reported among those who were victims or observers of this event (Wilkinson, 1983).

### **Avoidance of Reminders**

Avoiding reminders of a traumatic event was one of the coping strategies reported by survivors of two tornadoes (Madakasira & O'Brien, 1987; North, Smith, McCool & Lightcap, 1989), of an ambush (Feinstein, 1989), and of the collapse of the Hyatt Regency skywalks (Wilkinson, 1983). The experience of avoiding reminders of a traumatic event may alternate with intrusive recollections of the trauma, partly but not fully preventing painful awareness of traumatic memories. This is suggested by a recent study with Oakland/Berkeley firestorm survivors in which we found that avoidance and intrusive symptoms were highly correlated (Koopman, Classen & Spiegel, 1992).

## **DISSOCIATIVE PSYCHIATRIC DISORDERS IN RESPONSE TO TRAUMA**

Psychological reactions to trauma are varied in their timing, intensity and scope. Despite these differences, it appears that dissociative symptoms play a major role in more intense reactions, as well as playing a role in the normal symptom course in response to acute trauma. We discuss below five of the more intense reactions in which dissociative symptoms play a core role in the psychiatric disorder in the DSM IV: acute stress disorder, post-traumatic stress disorder, dissociative identity disorder, dissociative amnesia, and dissociative fugue. Although more research is necessary, it is logical to expect that acute stress disorder may lead to the other, long-term forms of dissociative disorders, or to anxiety or other disorders, depending on which symptom patterns dominate.

### **Acute Stress Disorder**

Acute stress disorder (ASD) has been proposed as a new diagnosis for the DSM IV (APA, 1987, 1993; Spiegel & Cardena, 1991). It is diagnosed when high levels of dissociative symptoms, anxiety and other responses occur within one month of the trauma, and persist for at least two days, causing distress and dysfunction (APA, 1993). Such individuals must have experienced or witnessed physical trauma, and responded with intense fear, helplessness or horror. This "A" criterion of the DSM IV requirements for ASD is identical to that for PTSD. The individual must have at least three of the following five dissociative symptoms: depersonalisation, derealisation, amnesia, numbing,

or stupor. In addition, the trauma victim must have one symptom from each of the three classic PTSD categories: intrusion of traumatic memories, including nightmares and flashbacks; avoidance; and anxiety or hyperarousal. If the symptoms persist beyond a month, the person receives another diagnosis based on symptom patterns. Likely candidates are dissociative, anxiety or post-traumatic stress disorders.

To understand the nature of acute stress disorder and its possible link to longer term dissociative disorders, it is important to examine the available empirical literature on the prevalence of transient symptoms during and in the immediate aftermath of trauma. While these studies suggest that such symptoms as intrusive recollections after trauma are widespread in trauma's immediate aftermath, the severity and persistence of such symptoms may indicate the presence of an acute stress disorder. At least 15 recent studies have examined symptoms in trauma's immediate aftermath. Although most of these studies on immediate reactions to trauma were not designed specifically to examine dissociative symptoms, nearly all of these observed that dissociative responses, as well as anxiety, intrusive and avoidance symptoms occurred in the immediate aftermath of trauma. These symptoms tend to decline with time (Berah, Jones & Valent, 1984; Cardena & Spiegel, 1993).

### **Post-Traumatic Stress Disorder**

Post-traumatic stress disorder (PTSD) is diagnosed when a pattern of chronic symptoms occurs beyond the first month after a traumatic event. The symptoms are parallel to those of ASD: intrusive remembering or reliving of the traumatic event, hyperarousal, and emotional numbing or avoidance of stimuli reminiscent of the trauma (APA, 1987; 1993). This pattern of symptoms was first observed among war veterans who exhibited these symptoms in response to their combat experiences (Fairbank, Keane & Malloy, 1983; Kardiner & Spiegel, 1947). More recently, this pattern has been found in cross-cultural research on Cambodian refugees who survived the Cambodian conflict (Carlson & Rosser-Hogan, 1991). PTSD has also been observed among survivors of disasters such as the *Exxon Valdez* oil spill (Palinkas, Petterson, Russell & Downs, 1993); tornadoes (Madakasira & O'Brien, 1987); and bushfires (Berah et al., 1984; McFarlane, 1986).

### **The Relationship between ASD and PTSD**

Several studies indicate that acute stress disorder symptoms predict the development of PTSD. Survivors of the Oakland/Berkeley firestorm who had acute stress disorder symptoms on the Stanford Acute Stress Reaction Questionnaire were significantly more likely to score within the PTSD range on the civilian version of the Mississippi PTSD Scale and the Impact of Event Scale (Koopman, Classen, & Spiegel, 1993). Similarly, "psychic numbing" in the aftermath of combat stress among Israeli soldiers accounted for 20% of the variance in PTSD (Solomon et al., 1989). McFarlane (1986) found that numbing and detachment after the Ash Wednesday bushfires in Australia

predicted later PTSD symptoms. Both ASD and PTSD symptoms may originate in the individual's capacity to access dissociative states and focus their attention (Spiegel & Cardena, 1991). This capacity is reflected in hypnotisability, which has been found to be high among Vietnam veterans with PTSD (Spiegel, Hunt, & Dondershine, 1988; Stutman & Bliss, 1985). The greater the capacity to dissociate, the more likely it is that an individual will develop ASD after a traumatic event. If individuals with ASD continue to rely upon their dissociative capacity for attenuating the pain of trauma, they may develop PTSD as a reaction to having too much unintegrated experience regarding the trauma.

### **Dissociative Identity Disorder**

Dissociative identity disorder (DID) is an extreme dissociative disorder that can also be conceptualised as a chronic post-traumatic stress reaction (Braun, 1986; Kluft, 1985; Ross et al., 1989; Spiegel, 1984). It has been renamed dissociative identity disorder from multiple personality disorder in the DSM IV (APA, 1993). This change in name was implemented to emphasise the fact that the fundamental disturbance is a failure of integration of aspects of memory and identity, rather than a proliferation of "personalities." Other changes in the diagnosis include the use of the term "presence" rather than "existence" of two or more identities or personality states. The requirement that one take "full" control has been amended by eliminating the word "full" to allow for situations in which one personality is in control, but is being influenced by another dissociated personality state, for example via auditory hallucinations. Also, the amnesia criterion has been reintroduced. It had been eliminated in DSM III-R (APA, 1987) but research indicated that more than 90% of individuals with the disorder have amnesia, and it is a useful symptom in establishing the diagnosis. Furthermore, this addition makes the diagnosis more stringent.

Researchers have found that DID is strongly related to the report of having experienced severe and multiple traumas (Type II; Terr, 1991) in childhood (Coons & Milstein, 1986; Putnam et al., 1986; Ross et al., 1990). Due to the high hypnotic susceptibility of people exhibiting DID, there is a debate about the accuracy of reported childhood trauma among persons exhibiting this disorder (Frankel, 1990). However, one study (Coons & Milstein, 1986) was able to independently corroborate the reports of trauma of 17 out of 20 DID patients, strengthening the evidence in support of a relationship between multiple childhood traumas and DID. In addition to multiple childhood traumas, it appears that DID also requires high dissociative ability (Frischholz, 1985; Spiegel, 1984), although research is needed to determine whether the trauma leads DID patients to develop the capacity to dissociate as a defence or they already had this capacity when the trauma began.

### **Dissociative Amnesia**

Dissociative amnesia in DSM IV, formerly named "psychogenic amnesia" in DSM III-R (APA, 1987), is the loss of memory for a period of time surrounding

a traumatic event. The memory loss is too extensive to be attributed to ordinary forgetfulness and is not due to DID or an organic disturbance (APA, 1993). The victim used his or her dissociative abilities to banish all memory of the traumatic experience from consciousness. The amnesia can be selective so that the victim fails to recall only certain aspects of a given period of time. Coons and Milstein (1988) found that 76% of a sample of 25 dissociative disordered subjects suffered selective amnesia. The amnesia can also be localised to a discrete period of time or it can be generalised such that the victim cannot recall events after a specific time and up to the present.

### **Dissociative Fugue**

The disorder labelled “psychogenic fugue” in the DSM III-R has been renamed “dissociative fugue” for the DSM IV. The diagnosis of a dissociative fugue describes individuals who suddenly and unexpectedly travel away from their home or work, are unable to recall their past and either lose awareness of their current identity or assume a new identity. The assumption of a new identity is no longer required for the diagnosis, since the majority of cases of fugue involve merely the loss of usual identity (Keller & Shaywitz, 1986; Reither & Stoudemire, 1988; Spiegel & Cardena, 1991; Venn, 1984). A link to trauma is suggested by the observation that the fugue state is usually preceded by intense and overwhelming affect (Reither & Stoudemire, 1988) and often is precipitated by psychic or physical trauma, by recalling unpleasant memories, or by other major stressors such as financial difficulties (Abels & Schilder, 1935).

## **TREATMENT CONSIDERATIONS**

Traumas endanger core beliefs about oneself, others and the world (Roth & Newman, 1990), and dissociative reactions permit the meaning of threats to remain out of full awareness and unintegrated (Spiegel, 1991a). The goal of treatment is the integration of traumatic memories with the remainder of personal history and identity, providing for management of painful affect and restructuring of the meaning of the traumatic experiences. The goal is to make them real but finite, reflecting more on the situation and less on the person. In traditional psychotherapy, the therapist’s aim is usually to help the patient assume greater responsibility for life problems, whereas in providing treatment to the trauma survivor, the therapist generally needs to help the patient assume less responsibility for the trauma (Spiegel, 1988). Cognitive restructuring and hypnotic approaches are recommended to promote this change in perspective.

### **Helping the Survivor to Relinquish Emotional Control**

Because the essence of physical trauma is helplessness, reactions to trauma often represent an attempt to deny helplessness by experiencing the event as though the victim were in control. However, experiencing a sense of control over the event is likely to be accompanied by a false sense of responsibility

for it, resulting in excessive and inappropriate guilt. A rape victim will apply hindsight and berate herself for having left her car to go to the store, as though she could have known the attack would happen. A soldier who survived a rocket attack may feel that he traded his safety for that of a comrade who died. While such things may, and indeed do, happen, more commonly there is little the victim could do to alter the outcome. Therapy is aimed at helping the victim acknowledge and bear the emotional distress which comes with traumatic memories, grieving the loss of control which occurred at the time and thereby admitting the uncomfortable sense of helplessness. Often trauma victims seek to control their emotions tightly when remembering the event, as though that shows greater strength or enhances their ability to control the events. In fact, they need to relinquish emotional control in the service of admitting a lack of physical control at the time of the trauma. The unbidden and intrusive memories constitute a re-enactment of the trauma, the trauma victim has lost control over his or her mental state even though physical control has been regained. It is a challenge to relinquish such tight emotional control in the service of regulating and working through the meaning of the experience. This challenge is heightened by the need for the therapeutic process to avoid exacerbating survivors' sense of helplessness by encouraging participants to express emotions or to make other self-revelations before they are ready. For this reason, it is critical at the onset of intervening psychologically with trauma survivors to establish a sense of safety prior to encouraging them to explore the traumatic event at a more intensely emotional level (Herman, 1992).

### **Restructuring**

This process of working through has been conceptualised as grief work (Lindemann, 1944; Spiegel, 1981, 1988), a process of bearing the loss of a sense of omnipotence and accepting the reality of physical and emotional losses. Freud (1914) conceptualised psychotherapy as a process of "remembering, repeating and working through". Conflicts and traumas are remembered, then repeated in the transference relationship in therapy, as part of the process of bringing them to attention. They are neither denied nor accepted at face value, but rather placed into a new perspective, making them more acceptable to consciousness. This process has been termed "restructuring" (Spiegel & Spiegel, 1978; Spiegel & Cardena, 1990). For example:

A social worker who was physically and sexually assaulted sought help with hypnosis to improve her memory of her assailant's face. She had suffered a basilar skull fracture during the assault and remained guilty about her intense resistance to the attack. She suffered as well the usual PTSD symptoms of heightened arousal when reminded of the attack, and loss of pleasure in usually enjoyable activities, along with intrusive recollections of the assault.

She was hypnotised and instructed to allow her body to float safely and comfortably while picturing the attack as if it were occurring on an imaginary screen in her mind's eye. She watched with fear and surprise the viciousness in her assailant's

eyes and observed that he had not expected her to fight as hard as she did. She recognised that his intention was not simply to rape, but to murder her.

She emerged from the hypnosis session with a more intense memory of the threat, but with a new perspective on it, that she may well have saved her life by fighting as hard as she did (Spiegel, 1989, p. 302)

As an aid in gaining insight in immediate and long-term intervention for trauma survivors, hypnosis can be a valuable tool. This makes sense since hypnosis is formally elicited dissociation (Nemiah, 1985; Spiegel & Spiegel, 1978). If dissociation occurs spontaneously in response to trauma, it makes sense that bringing about a similar state would facilitate the retrieval of trauma-related memories (Spiegel & Cardena, 1990, 1991). Techniques such as hypnosis may be extremely helpful in facilitating psychotherapy by:

1. facilitating entry into a well-controlled state of physical relaxation and a feeling of safety;
2. dissociating emotionally arousing and uncomfortable mental content from the somatic response to it;
3. providing a controlled focus of attention to the traumatic memories;
4. permitting abrupt disconnection from these memories after the grief work has been accomplished; and
5. facilitating recall by allowing entry into a mental state similar in some important ways to that experienced during trauma (Spiegel et al., 1988; Spiegel, 1988).

However, psychotherapeutic support for individuals in the acute as well as chronic aftermath of trauma can be conducted effectively without such special techniques. It involves ventilation, establishing a new emotional equilibrium, and restructuring traumatic memories (Krystal, 1978; Spiegel & Cardena, 1990). It is desirable to begin offering this kind of support as soon as possible to survivors of a disaster, particularly those manifesting serious ASD symptoms. However, it is not always feasible to identify and enrol survivors immediately in psychological intervention programmes because survivors are often busy assessing and coping with the immediate material consequences of the disaster (e.g., locating short-term sources of food and shelter to substitute for those lost) and because they may not be ready to deal with the psychological impact in the immediate aftermath. Days after the traumatic event, anger, depression and other symptoms are likely to intensify among many survivors, sensitising them to the continuing psychological impact of the event and perhaps increasing their receptivity to psychological help and support.

### **Eight “Cs”**

Psychological interventions for trauma counselling can be summarised with a series of eight “Cs” (Spiegel & Cardena, 1990):

1. *Confront* trauma.
2. Find a *condensation* to the traumatic experience. This allows a finite series of memories to symbolise the trauma, making the memories finite and manageable.

3. Allow for *confession*. Many trauma victims find the memories degrading and humiliating. The very act of admitting them to someone else makes them feel less isolated and unacceptable.
4. Provide *consolation*. Appropriate expressions of empathy go a long way toward acknowledging the normality of an extreme reaction to an extreme experience. Detachment or disinterest conveys rejection. Trauma victims need to feel acceptable even with their burden of uncomfortable recollections and experiences.
5. Make *conscious* previously dissociated material. The need to keep important events out of conscious awareness exacts an emotional and cognitive toll, interfering with normal functioning. Furthermore, making the material conscious facilitates working through the traumatic memories.
6. Utilise focused *concentration* in the working through of traumatic memories. The process of psychotherapy provides ceremonial boundaries around the accessing of traumatic memories, conveying the message that they may to some extent be put aside once the therapy session is over.
7. Enhance the victim's sense of *control* over the traumatic memories. The process of the therapy must reinforce the content by giving the victim a greater sense of control over traumatic memories and in the relationship with the therapist.
8. Facilitate the development of *congruence*, the incorporation of traumatic memories into an integrated and acceptable view of the self. Psychotherapy and other forms of support can enhance adjustment to trauma and mitigate both acute and chronic stress response syndromes.

## CONCLUSION

Current research and clinical practice indicate a strong relationship between dissociation and trauma. This has led to the development of a new diagnostic category: acute stress disorder, which includes dissociative and anxiety symptoms occurring in the immediate aftermath of traumatic stress. This category should facilitate further research on peritraumatic dissociation, and its relationships with subsequent PTSD and with other dissociative disorders. The role of dissociative defences during and after trauma suggests the special utility of psychotherapeutic techniques employing hypnosis and other cognitive restructuring approaches in mobilising and working through the residue of traumatic stress.

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## FORENSIC HYPNOSIS: UNANSWERED QUESTIONS

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Many courts have mistakenly identified hypnosis as more suggestive than eyewitness testimony or leading questions, and therefore these courts have applied unnecessarily restrictive rulings on hypnosis. The dangers of suggestion in eyewitness and interrogation cases pose reliability problems that are equally as great. In all situations, pre-trial evidentiary hearings on admissibility of "suggestive" testimony is essential. Expert testimony should be available to assist the judge. The forensic rules to date have failed to clarify some hard cases. In resolving these cases, courts are encouraged to adopt a case-by-case analysis rather than a total prohibition on hypnotically refreshed recollection.

Courts have assumed conclusions about hypnosis that the laboratory experiments suggest are incorrect – juries are not overly persuaded by hypnosis testimony, there is no inevitable concreting effect and witnesses do not become impervious to cross-examination. Thus, the restrictive per se disqualification rules for hypnotically refreshed recollection are too severe.

Hypnosis took a beating in American courts of law in the 1980s. Most judges shied away from permitting hypnosis to be used as a memory refresher on the grounds that it is fraught with dangers of confabulation, concreting, and source contamination.

For the moment, there is a relative tranquillity in the law of forensic hypnosis. A couple of states in the U.S. have rulings that permit hypnotically refreshed recollection to be admitted into evidence. Most states, however, prohibit persons who have been hypnotised from testifying in court, except as to duly recorded pre-hypnotic recollection. A significant number of states permit hypnotically refreshed recollection if either certain guidelines [or safeguards] have been followed, or if, under the totality of the circumstances, the hypnotically refreshed recollection does not appear to be too unreliable (Schefflin & Shapiro, 1989).

The basic law of forensic hypnosis has been settled in most jurisdictions. Yet, despite approximately 700 judicial opinions on the topic, many crucial

questions remain unanswered. As the courts turn to resolving these questions, it is to be hoped that they re-examine their highly restrictive rules and adopt a position in favour of recognising the admissibility of hypnotically refreshed recollection on a case-by-case basis. The present majority rule, which automatically disqualifies any post-hypnotic recollection is unfair, unjust, and unnecessary.

A judicial rule should only stand for as long as it appears to be just and fair. In judging fairness, courts have been primarily concerned with the *accuracy* and *reliability* of hypnotically refreshed courtroom testimony. The right of the patient to be healed, and the right of the therapist to practise competent therapy, have been of far lesser concern to judges. There is good reason to believe that this lopsided equation needs to be adjusted, and the following unanswered questions will help show the basic inequities in, and the fundamental unfairness of, the present prevailing per se disqualification rule which has been adopted by a majority of courts.

### SEX WITH HYPNOTISTS

Suppose the therapist uses hypnosis to induce trance and then has sexual relations with the patient. Unfortunately, many such cases are pending in courtrooms across the country,<sup>1</sup> and the participants are often paraded on national and local television talk shows. May the therapist argue that because of the hypnosis, the patient is disqualified from testifying? At least one court has held that the answer is "yes" (Spiegel, 1987).

Imagine a rapist who "hypnotises" his victims immediately after assaulting them. Under a strict reading of the prevailing judicial rule, his victims could not testify against him.

Indeed, not only would the victims be unable to testify, the police would be unable to obtain evidence by using undercover officers masquerading as potential customers. As soon as hypnotic techniques are used on these officers, they too would become disqualified as witnesses. The assaulter would become "investigative-resistant" and "conviction-proof." In these seduction cases, the per se inadmissibility rule becomes a licence to rape. Some courts are reaching a more sensible result.

In *Matter of Raynes* (1985), a police officer, with a longstanding exemplary record, opened a private hypnosis service to aid people suffering from weight and smoking problems. Business prospered, but rumours began to spread of sexual advances made by Raynes toward his female customers. The Police Commission held a hearing to determine whether Raynes' activities violated the police code of conduct. Five women were permitted to testify that Raynes used hypnosis with them prior to initiating sexual contact. The hypnotic

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<sup>1</sup> Many hypnotic seduction cases never reach the appellate courts, so it is difficult to estimate their precise number. At present, 20 hypnotic seduction cases have been decided by appellate courts in the US.

inductions themselves were filled with sexual images. The Supreme Court of Montana upheld Raynes' dismissal from the police force, but the court did not discuss the legal issue of the admission of post-hypnotic testimony (Watkins, undated).

In *Hickey v. Askren* (1991), the plaintiff alleged a series of torts committed by her defendant-therapist when he had sex with her while providing therapy. Unfortunately for her, the statute of limitations had run on all counts. The Georgia court found that this was not a case of repressed memory, and that there was "no evidence that [her] therapy included the use of drugs, hypnosis or any other treatment whereby [she] may have incurred damage without her knowledge, so as to render this case analogous to situations when a patient's injury has been concealed by the fraud of the tortfeasor" (*Hickey v. Askren*, 1991). Thus, the statute of limitations would not run in a case where a defendant used hypnosis to seduce a patient. But, even if the statute would not bar the plaintiff's claim, would the plaintiff be permitted to testify as to these post-hypnotic events? The Georgia court was silent on this point.

In *People v. Sorscher* (1986), a Michigan court was explicit on the point. The defendant, a dentist who used hypnosis on patients and friends, was accused of making sexual advances to males. He argued that the testimony of the alleged victims was inherently unreliable because it concerned events which occurred while the witnesses were in an hypnotic trance. Michigan followed a rule that hypnosis produces inherently unreliable results thereby tainting witnesses from providing admissible testimony (*People v. Gonzales*, 1983). Should the dentist be permitted to suppress all the truthful testimony?

The court refused to apply the Michigan per se exclusion rule to this case:

We perceive that the thrust of *Gonzales* is to exclude testimony which has been obtained through hypnosis as a method for improving a witness's memory . . . In the case at bar, hypnosis was not used as a scientific technique to obtain evidence against defendant . . . Rather it was used by defendant as an aid in the commission of a sexual assault.

Moreover, we hold that, as a matter of public policy, a defendant should not be able to put a person under hypnosis, sexually assault that person and then claim that the person is incompetent to testify because the testimony is tainted by hypnosis (*People v. Sorscher*, 1986, p. 368).

It makes little judicial sense, and serves no cause of justice, to exclude post-hypnotic recollections in these sex cases. But, once the testimony is admitted in these cases, is it fair to exclude post-hypnotic testimony in *all* other types of cases?

## SELF-HYPNOSIS

Suppose the victim of a violent crime buys and listens to a self-hypnosis relaxation tape. These tapes, most of which are admittedly of questionable value, are now available everywhere. Will this victim thereby be disqualified

from testifying in court because she has been “hypnotised” by this tape? Technically, the answer is “Yes” though no case has yet decided this precise issue.

In the Ohio case of *West v. Howard* (1991), the plaintiff’s car and that of the defendant collided. The plaintiff brought suit but had no memory of the events leading up to the crash, and no memory of the crash itself. The plaintiff sought the assistance of a social worker trained in trance techniques who taught her self-hypnosis and who supervised the gradual memory recall.

The Ohio Supreme Court, in *State v. Johnston* (1988), had previously ruled that hypnotically refreshed recollection would be admissible provided the trial judge determines, by clear and convincing evidence, that under the totality of circumstances the testimony is reliable. The Orne guidelines are used as factors the trial judge may consider.

Would this ruling apply to self-hypnotic techniques? The Court of Appeals in *West* said yes:

this court is of the opinion that a hypnotic technique, such as the one used in the case before us, in which the patient or client herself controls the memory retrieval process could never meet the standard for reliability set forth in *Johnston* . . . The guidelines and factors enunciated by the *Johnston* court require that the hypnosis session be conducted by a neutral qualified mental health professional and that the process of retrieval be documented so that it can be reviewed by the court for the dangers inherent in that process. The technique of self hypnosis, as employed in this case, involves none of these safeguards and, because it is a learned technique, is subject to all of the dangers associated with hypnotic therapy . . . That is, the suggestiveness involved in learning the technique and [plaintiff’s] motivation for retrieving the memory render any subsequent memories refreshed through self hypnosis inherently unreliable (*West v. Howard*, 1991, p. 533).

The *West* court was probably influenced by its view that although “self hypnosis” is allegedly at issue, the social worker was “fully involved in the retrieval process and . . . there was considerable interaction” between the plaintiff and the social worker. Furthermore, the plaintiff was encouraged to remember the accident “in order to relieve her emotional feelings” regarding the crash. Accuracy of the memory was thus less important than the emotional catharsis. The dangers associated with hypnotic memory retrieval are fully present in this situation.

Another case that raises the issue of self-hypnosis as a means of refreshing memory is *State v. Schreiner* (1991), which has a somewhat unusual fact pattern. The defendant Schreiner was tried for attempted murder and found not responsible because of a mental disease or defect and he was sent to a psychiatric hospital. As part of his treatment, Schreiner received hypnotic therapy and was taught self-hypnosis. Both techniques were used for the purpose of relieving Schreiner’s feelings of guilt and to help him remember whether he had committed other crimes.

After several years, doctors pronounced Schreiner cured and a hearing was scheduled concerning his transfer to another facility. Schreiner agreed to a



psychiatric examination and was told that whatever he said would not be confidential and would be turned over to the prosecutor. Nevertheless, during the examination, Schreiner stated that several years earlier, following a "self hypnotic episode" he "remembered" that he had killed Jamie Amsterdamer.

Schreiner is now on trial for the murder of Amsterdamer. He wants to suppress his statement as a product of hypnosis. Schreiner's therapist, to whom he confessed the crime years before revealing it at the psychiatric examination, testified that although Schreiner "was not under hypnosis when he told her of these events, his statement resulted from the 'therapy or post hypnotic suggestion.'" Schreiner provided expert support for the claim that his statement had a "high probability of confabulation."

The New York Court of Appeals held that:

the record supports no other inference than that defendant's statement was hypnotically induced. The evidence was that he initially thought he had not committed the Amsterdamer murder about which he had been questioned and that he "remembered" his involvement following an episode of self hypnosis. The conclusion is thus inescapable that his recollection was the result of hypnotic therapy and post hypnotic suggestion. Because such recollections are inherently unreliable, the defendant's statement should not have been admitted into evidence against him (*State v. Schreiner*, 1991, p. 556).

The most recent case to raise this self-hypnosis issue is *People v. Sterling* (1992), a New York County Court decision. The defendant was the prime suspect in the murder of a 74-year-old woman whose testimony as a rape victim resulted in the conviction of the defendant's brother for the offence. The defendant received full notification of his rights and was well aware the police had focused their investigation on him. Police officers picked up the defendant at 5.45 p.m. on the night of 10 July 1991, for more questioning. At that time the defendant agreed to submit to a polygraph and to answer police questions. He was aware that he was not under arrest and that he was free to stop talking or to leave whenever he wished.

At 11.20 p.m., Inspector Crough began questioning the defendant. Crough talked with the defendant about the defendant's "anger because his brother had been wrongfully accused and convicted of raping Violet Manville." Crough said he thought the defendant had hurt Manville but did not mean to let things "go that far."

The defendant requested hypnosis to help him remember the events of that night. The police refused permission for hypnosis. At 12.45 a.m. the next morning the defendant again asked to be hypnotised and was again refused. Officer Sennett, who had no training in relaxation, responded when defendant asked for help to relax, by "asking the defendant to lay down on the floor, to keep his feet up on the chair and to take 4 deep breaths." Sennett held the defendant's hand. After questions seeking memories of that evening, defendant responded that he saw himself walking on the path and he saw, in the bushes, the naked body of "the lady with the white hair." When asked

his feelings, the defendant said: "Now I'm feeling happy." The defendant then jumped up saying "This is all bullshit. I didn't do nothing." The defendant then threw his glasses against the wall.

Following dinner at 2 a.m., defendant's third request to be hypnotised was rejected. He was told the police knew he did it and that he would feel a lot better if he would admit it. Crough and Sennett began massaging the defendant's back and shoulders telling him, in a soft voice, that he must be in pain. They told him he would feel better if he told the truth. The defendant confessed.

The court concluded that the defendant was never under arrest, had been fully informed of his rights, had been made no false promises or representations and had experienced no improper conduct or undue influence. Thus, the confession was voluntary.

The defendant argued that he had undergone a "self hypnotic" experience which resulted in his confession. An expert psychologist testified that the defendant "was highly responsive to hypnotic suggestion, and had an unusually high hypnotic capacity as measured by the Hypnotic Induction Profile, the Barber Suggestibility Test and the Barber Creative Imagination Scale." Thus, there was a "very high likelihood" that the defendant "underwent a hypnotic event" while being questioned. The expert said it was "self hypnosis in response to circumstances he was exposed to."

The defendant claimed he had learned a hypnotic relaxation technique, similar to that used by the police who questioned him, from a friend, and that he still used the technique as a way to deal with stress.

Dr Herbert Spiegel testified for the prosecution. After examining the defendant using the Hypnotic Induction Profile and "a cluster structural survey, i.e., a personality test," Spiegel said that although the defendant was in the top 25% of the population in hypnotisability, there is no evidence that he actually was in trance during the questioning. Relaxation is different from hypnosis and no formal induction ceremonies for hypnosis had been present. According to the judge, "even if this court dispensed with a showing that a defendant underwent a formal induction event, the credible evidence does not support the defendant's contention that he underwent a self hypnotic event when relaxed by Officer Sennett. The court adopts the testimony of Dr Spiegel and finds it credible."

Does the New York per se exclusion rule, *People v. Hughes* (1983), apply where there are no formal induction ceremonies? The court held it did not. Noting that all prior New York cases involved a formal induction process, here the fact that "a friend with no known training or expertise allegedly taught him a relaxation technique" is not a sufficient basis to say that the defendant experienced a hypnotic event. Thus, "there was no hypnosis as defined in New York and no suggestion made in hypnosis that might infect his later statement." What ultimately is the rule for admissibility of memories recovered after self-hypnosis? No court has answered this question.

## NONHYPNOSIS HYPNOSIS

Police, sensitive to the restrictive rulings involving hypnosis, are presently utilising hypnotic techniques, but refraining from calling them “hypnotic.” Do the exclusionary rules pertaining to hypnosis also apply to “visualisation,” “guided imagery,” or “relaxation”? So far, a rose by any other name is not, in the eyes of the law, a rose.

In *State v. Varela* (1991), a child was referred to a psychotherapist after suffering nightmares, mood swings and other problems. At first the child revealed very little. The therapist used “relaxation therapy”<sup>2</sup> and the child made a first report about being sexually abused by the defendant.

The child testified that the relaxation therapy did not bring back memories because she had not forgotten or repressed the sexual assaults. Because there was no pre-relaxation statement from the child, and the only testimony about the molestations was post-relaxation, the issue was raised as to whether the child was disqualified from testifying under New Mexico’s *Beachum* decision (*State v. Beachum*, 1981), which had adopted the requirement that the “Orne guidelines” be followed before hypnotically refreshed recollection would be admissible.

The New Mexico court distinguished *Beachum* in two respects. First, *Beachum* involved the use of traditional hypnosis, whereas in this case, Ericksonian hypnosis had been used. There is evidence in the record that Ericksonian hypnosis does not create the same reliability problems as traditional hypnosis.<sup>3</sup> Second, the subject matter of the disclosure by the hypnotised witness was totally unanticipated by the hypnotist. This was not a case conducted for forensic purposes.<sup>4</sup>

In a circumstance where “it is totally unanticipated that the hypnosis session will produce a disclosure relevant to litigation,” the safeguards of *Beachum* are quite meaningless. That does not mean, however, that this “therapeutic” hypnosis is free of reliability problems. With *Beachum* inapplicable and the reliability problems present, what rule should be adopted?

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<sup>2</sup> The psychotherapist described this technique “as telling the child to take a few deep breaths, to begin to notice the sounds outside and to think about what she was feeling” (*State v. Varela*, p. 733). The therapist’s supervisor said the technique was “Ericksonian hypnosis” but he also stated that practitioners of traditional hypnosis would not label the technique as hypnosis. Both testified that there was a minimal risk of suggestion.

<sup>3</sup> The court continued: “Nevertheless, we believe that the record in this case is inadequate for us to state definitively that the *Beachum* safeguards are unnecessary when Ericksonian hypnosis is used. We therefore do not rest our decision on that ground. We leave that issue to a further case.”

<sup>4</sup> The court continued: “It is undisputed that the purpose of the hypnosis of the victim was therapy and no one present at the session, with the possible exception of the victim herself, had any reason to believe that the victim would disclose any allegations of sexual abuse . . . The surprise was not in the matter of detail – such as the identity of the perpetrator of the crime – but of the very existence of an offence.”

The New Mexico court chose to put its faith in trial judges. In these “therapeutic” hypnosis cases where legally relevant disclosures are unexpected, trial judges should determine whether the state has shown, by clear and convincing evidence, that the use of hypnosis in this case “was reasonably likely to result in recall comparable in accuracy to normal human memory”.<sup>5</sup>

The New Mexico result protects patients and therapists without unduly infringing the rights of defendants.

Colorado has also protected the victim in *People v. McKeegan* (1986). Here, the victim of an alleged sexual assault was treated by a mental health counsellor with “hypnotic relaxation therapy” which consisted of “physical relaxation, deep breathing and visualisation of being in a pleasant place.” According to the court, “[the victim] was not questioned and no suggestions were made to her under hypnosis; rather, the sole purpose of the hypnosis was to allow her to relax and overcome her anxiety about testifying.” The defendant argued that the hypnosis disqualified the witness from testifying. The court disagreed. Because the hypnosis was not used to refresh the witness’s memory, none of the prior restrictive rulings was applicable. Nothing in the record indicated that the victim was given suggestions and nothing indicated that she made relevant remarks while in trance.

The defendant claimed that “even if her memory were not refreshed, her hypnotic relaxation so affected her demeanour before the jury as to deny him due process of law.” The court rejected this argument by noting that the defendant was free to use the hypnotic relaxation to impeach the victim’s credibility, but not to deny her the right to testify. *Murray v. State* (1991) raised the interesting issue of whether the use of “progressive relaxation” techniques constitutes “hypnosis.” The court held that it did not. In this case, the victim underwent a hypnotic procedure which the psychologist called “progressive relaxation.” In court, the psychologist testified that this procedure “is an induction that you can use for hypnosis,” but he stated that, in his opinion, the victim was not hypnotised: “I believe [the victim] to be in a heavy state or in a good solid state of relaxation. As far as trance state hypnosis, I do not believe that she reached a trance state of hypnosis.”

The court held that the victim was not hypnotised and therefore could testify.

In these cases, courts must make a case-by-case analysis to determine whether undue suggestion occurred. Why should the name of the technique make any difference? The real issue is whether the evidence is reliable. To answer that inquiry, a per se disqualification rule is unfair in precisely those cases where hypnosis, or a similar technique by another name, uncovers reliable and accurate information.

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<sup>5</sup> The court said that because the child’s revelations came as such a complete shock to the therapist, the trial judge: “could properly determine that the possibility of improper suggestion at the session was sufficiently small that the victim’s testimony should be admitted at trial. Indeed, the district court could find that the victim’s recollection predated the session and was not refreshed by hypnosis.”

## FALSE CONFESSION CASES

A problem about the reach of the anti hypnosis per se disqualification rule remains unresolved in cases of spontaneous hypnosis. Courts have generally seen hypnosis issues within the context of a formalised ritual trance induction, deepening techniques, age regression or memory enhancement and trance conclusion. What of cases where spontaneous trance occurs, such as in police interrogation situations? As Behars (1989) noted: "Both hypnotic phenomena and hypnotic transactions occur widely outside a professional setting, or in structured settings whose overt purpose is not to achieve or utilise hypnosis per se" (p. 173).

Herbert Spiegel is credited with first raising this issue in 1976 in the famous *Reilly v. Connecticut* (1976) case, where the police talked a highly suggestible young man into confessing that he killed his mother (Connery, 1977). More recently, Ofshe (1989, 1992) provided detailed instances of false confessions in police investigations that were not formal hypnosis sessions, but which utilised trance techniques. Gudjonsson (1992) has done extensive work in England on false confession cases and a detailed description of the use of trance techniques in police interrogations may be found in the briefs in the California Supreme Court case of *People v. Alcala* (1992).

Cases of spontaneous trance, and false confession cases, raise a larger problem about the role of suggestion in general, apart from formal trance procedures (Gheorghiu, Netter, Eysenck, & Rosenthal, 1989; Schumaker, 1991). It is senseless for the courts to maintain a rule that is easily avoided by not using the word "hypnosis," or is ignored where subjects go into trance unnoticed.

## CIVIL CASES

Despite the many court rulings on forensic hypnosis in the last two decades, there are no general rules about hypnosis in civil cases. Approximately, 20 legal cases deal with civil issues and no general rule may be extracted from them.

Must amnesia caused by traumatic accidents persist because hypnosis cannot be utilised to offer relief? Three people are driving in a car when suddenly it swerves off the highway and plunges into a lake. Only one person, the car's owner, survives the tragedy. He has no memory of either the accident or the events preceding it. The parents of one of the passengers sue the surviving owner. At issue is who was driving the vehicle – the deceased plaintiff or the surviving defendant/owner? If all other memory restoration techniques fail, may hypnosis be used to obtain an answer? The court in *Savin v. Allstate Insurance Company* (1991) faced this issue but did not resolve it.

Hughes (1991) noted that legal rules concerning the admissibility of hypnotically refreshed recollection have not been settled in civil cases. Only Missouri appears to have clearly articulated its rule in a civil case. In *Alsbach v. Bader* (1985), the Missouri Supreme Court adopted a per se exclusion rule.

The court rejected the safeguards approach because “such safeguards do not adequately address how a lay person, such as a trial judge or juror, will recognise when the hypnotised subject has lost his critical judgment and begun to credit ‘memories’ that were formally viewed as unreliable. Nor do safeguards provide a means for distinguishing between actual recall and confabulation invented and employed to fill gaps in the story.” The Supreme Court concluded that hypnotically refreshed recollection did not meet appropriate standards of reliability and accuracy.<sup>6</sup>

Current research, however, challenges some of the basic negative attitudes held by courts regarding hypnosis. In general, courts identify six problems with the reliability of hypnotically refreshed testimony:

1. The subject becomes “suggestible” and may try to please the hypnotist with answers the subject thinks will be met with approval.
2. The subject is likely to “confabulate,” that is, to fill in details from the imagination, in order to make an answer more coherent and complete.
3. The subject experiences “memory hardening,” which gives him or her greater confidence in both true and false memories, making effective cross-examination more difficult.
4. Pseudomemory.
5. Source amnesia.
6. Loss of critical judgment.

Researchers have shown, however, that these problems are not special to hypnosis and may be no more serious with hypnosis than without it. In other words, memory contamination is a function of memory, not of the use of hypnosis to facilitate recall (Loftus, 1980).

Court concerns can be grouped into two categories: believability and reliability.

## **BELIEVABILITY**

Judges believe that restrictive admissibility rules regarding hypnotically refreshed recollection are essential to protect against the inevitability that jurors will give significant weight to hypnosis as a truth-finder and accurate memory retrieval technique. A recent study, however, suggested that the reverse may be true. Simulated jury experiments have led researchers to conclude that jurors are likely to view hypnotically refreshed evidence with scepticism. They are further likely to discount corroborating testimony of other witnesses who were not hypnotised (Greene, Wilson & Loftus, 1989).

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<sup>6</sup> In *State v. Reasonover*, 714 S.W.2d 706 (Mo. App. 1986), cert. denied 480 U.S. 936, 107 S.Ct. 1580, 94 L. Ed.2d 771 (1987), the *Alsbach* (1985) opinion was held to apply prospectively only. *Greer v. State*, 788 S.W.2d 546 (Mo.App. 1990), and *State v. Blackman*, 826 S.W.2d 76 (Mo.App. 1992) reaffirm these rules.

## RELIABILITY

### Hypnosis Creates Undue Suggestion

Researchers now believe that undue suggestion may be equally possible with clever interrogations and leading questions (Loftus, 1993). Thus, undue suggestion is also prevalent in non-hypnotic situations, more so than has been previously believed. Spanos and his associates have concluded their findings provide no support for the notion that hypnotic interrogations facilitate the formation of pseudomemories (Spanos, Gwynn, Comer, Baltruweit, & deGroh, 1989).

### Hypnosis Causes Confabulation

Recent memory research has shown that confabulation may be a natural way in which memory works, rather than a by-product of hypnotic trance. Experiments with eyewitness testimony have demonstrated confabulation in non-hypnotic settings and have also demonstrated that hypnotically refreshed recollection is not necessarily confabulated (Loftus, 1979; Wells & Loftus, 1984).

### Hypnosis Causes Undue Self-Confidence

Courts generally believe that hypnosis will give the subject an undue self-confidence in the accuracy of hypnotically refreshed recollections. This self-confidence will be based on a genuine, sincere belief that the memories and pseudo-memories are real and true. As the court noted in *State v. Ture* (1984), "effective cross examination of a previously hypnotised witness is virtually impossible." This has been labelled the "concreting" effect.

Preliminary studies are beginning to contradict the assertion that hypnotically enhanced pseudomemories are more resistant to cross-examination than are pseudomemories produced by skilful, suggestive interrogation (Spanos et al., 1989; Spanos, Quigley, Gwynn, Glatt, & Perline, 1991).

In *State v. Dreher* (1991), the court noted that:

the defendant's argument that, because of the hypnosis session, [the hypnotised subject's] trial testimony was delivered with an aura of confidence which it would not otherwise have had is not persuasive. The memory hardening process is an intrinsic part of a witness's preparation for trial. While ordinarily it takes the form of numerous pre-trial interviews and interrogations by counsel, the result is the same as that which defendant claims occurred here: a witness who testifies with conviction and believability. The fact that the witness has been prepped to testify effectively does not disqualify his evidence so long as it has not been falsified. (*State v. Dreher*, 1991, p. 220-221)

## CONCLUSION

At the present time, patients risk not getting valid, competent and essential hypnotherapy, and hypnotherapists risk malpractice liability. This situation must change.

On the basis of laboratory experiments and the analysis of hard legal cases, the per se exclusion rule should be replaced with a pre-trial hearing on the issue of undue suggestion.

Sheehan and McConkey (1993) are surely correct when they observe that it is extreme to take the view that all hypnotically obtained information should be ignored. Sadoff and Dubin (1990) reached a similar conclusion when they observed that the courts must decide, on a case-by-case basis, the admissibility of hypnotically recalled material. These authors also were opposed to the admissibility per se and the exclusion per se rules.

The forensic hypnosis community should move quickly to develop stringent and effective ethical and legal guidelines for the conduct of forensic hypnosis interviews (Sheehan & McConkey, 1993) and the American Society of Clinical Hypnosis has moved in this direction by appointing a select panel of experts to draft such guidelines. It is to be hoped that when these guidelines are completed, hypnosis can regain its legal respectability.

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## **THE PROTECTION OF THE PROFESSIONAL USE OF HYPNOSIS — THE NEED FOR LEGAL CONTROLS**

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A review of the published literature highlights the adverse effects that may occur through the use of hypnosis in a variety of contexts; by therapists lacking appropriate training in hypnosis; by those with a lack of clinical experience; most especially by lay practitioners; and in the context of "stage performance." The adverse effects range from the transient sequelae that are a minor nuisance and easily dealt with by an experienced practitioner, to severe psychiatric difficulties resulting in a need for major intervention and sometimes hospitalisation. These adverse effects highlight the need for controls over the practice of clinical hypnosis. The paper reviews the current situation around Australia.

At a time when all professions are under pressure from those who would present expertise as a form of elitism, the controls over the practice of hypnosis (as inadequate as some of us may feel they are) are being challenged. In order to rationally define our response to these challenges we need to consider a number of questions. Principally, we need to consider the arguments supporting the control of the clinical practice of hypnosis. Having established there is a need to control the clinical practice of hypnosis, what form ought these controls take? Additionally, we must question the need to control other aspects of the practice of hypnosis, such as its use in entertainment.

On what grounds might one wish to assert that any practice needs controls? It would seem that any practice which has the potential to cause harm to individuals, their social milieu, or to society might be considered to require some controls. There are many different types of harm that might be considered. Adverse effects may relate to a person's physical health, their short-term and long-term psychological well-being (distress), and their social or financial well-being.

MacHovec (1988) attempted to specify such adverse effects in relation to hypnotic practices.

Hypnosis complications are unexpected, unwanted thoughts, feelings or behaviors during or after hypnosis which are inconsistent with agreed goals and interfere with the hypnotic process by impairing optimal mental function. There is no prior incidence or history of similar mental or physical symptoms. They are non-therapeutic . . . or anti-therapeutic. (pp. 46)

In relation to hypnosis, is there evidence of adverse effects from its use in any domain and, if so, to what are such adverse effects attributable? Is there evidence that hypnosis itself, as a state or set of phenomena, can cause harm in any of these domains or can adversely affect the result of the way hypnosis is utilised and the suggestions given in trance?

### **ADVERSE EFFECTS OF THE EXPERIENCE OF HYPNOSIS**

Early concerns about the possible adverse effects of hypnosis were related to the issue of volitional control and the potential for the hypnotised subject to act in ways in which they would not otherwise behave or accept. In particular, concern focused on the commission of criminal offences and the alteration of volitional control in the many cases of sexual abuse and seduction that had come to the attention of the authorities. These concerns were expressed as early as 1784 by the Commission to Investigate Mesmerism set up by the French government.

The issue of volitional control and hypnosis is beyond the scope of the present article. Suffice to say the answer to the question "Can subjects be caused, as a result of hypnosis, to act in ways that they would find unacceptable or potentially harmful to themselves or others?" remains equivocal. "Maybe yes, maybe no," depending on the context, subject characteristics, the techniques used, and the psychological processes which may be outside the participant's awareness.

Does the state of altered cognitive processes resulting from hypnosis itself pose a danger? It is unlikely that a "state" that is available within most people's repertoire of psychological functioning could in itself be physically harmful. Seldom does nature provide a species with a characteristic that by its very nature causes harm to a member of that species.

The context within which the state is induced may present some problems. If the alteration of cognitive processes interferes with what a person may need to do to maintain their safety then it might be harmful. Such a situation arises with so-called "highway hypnosis" where the danger lies in the distraction from activities that need to be attended to. Such spontaneous states are not of concern here. It is possible that similar difficulties can arise through the deliberate induction of the hypnotic phenomena, but this is not a consequence of the phenomena but the context in which it is being used.

Similarly, it is feasible that the use of specific suggestions may interfere with the usual ability of a person to protect themselves. In particular, the alteration of pain perception may, if not done carefully, present the patient

with increased risk of failing to respond protectively to a new source of pain or alterations in the condition being treated.

Does hypnosis pose a risk to anyone's psychological health and well-being?

Since the beginnings of the professional therapeutic use of hypnosis (in fact since the work of the Marquis de Puysegar in 1784) there has been concern expressed about the possible adverse effects of clinical hypnosis (Conn, 1981; Eastabrooks, 1943; Meares, 1960, 1961; Orne, 1965; Rosen, 1960; Weitzenhoffer, 1957; Williams, 1953; Wolberg, 1948) and, in particular, the use of hypnosis by lay practitioners or as a form of entertainment (Weitzenhoffer, 1957; Wolberg, 1948).

Reported adverse effects have included depressive reactions, the precipitation of panic attacks, and the onset of psychotic disorders. However, clinicians and researchers are not of one mind on this issue. Some suggest hypnosis is without any dangers (Janet, 1925; Le Cron, 1961). Others maintain hypnosis may only pose risks if incorrectly applied (Yapko, 1992). And others suggest hypnosis is, in itself, potentially dangerous with some patients.

What is the evidence that such adverse effects exist? Numerous studies and opinions concerning potential adverse effects have appeared in the hypnosis literature over the past hundred years. Three types of evidence are available: clinical anecdotes or case reports; surveys of practitioners; and interviews with participants in clinical, research, and entertainment settings.

## **CLINICAL ACCOUNTS**

The Marquis de Puysegar in 1784 expressed concerns about the potential adverse effects of hypnosis when he created "accidental somnambulism" (Conn, 1981).

By the middle of the nineteenth century, frequent concerns were being raised about the use of hypnosis, although in the first instance these related to the manipulation of patients to act against their will or to their seduction (Conn, 1981; Reiter, 1958).

In the first half of this century numerous reports appeared concerning the sequelae of hypnosis. Hilgard, Hilgard, and Newman (1961) reviewed the literature in which it was claimed that headaches, tremor, neurotic, and psychotic symptoms could arise from the clinical application of hypnosis. They noted 15 cases of hypnosis related to the development of psychotic symptoms in the previous 50 years, and argued that, in most cases, these adverse effects occurred in subjects who had a long history of pre-existing disturbance.

Clinical accounts of complications arising from hypnosis appeared sporadically and in his landmark text on fact and fiction in hypnosis, Marcuse (1959) highlighted 11 major areas of concern. These related to the psychological well-being of the subject involved; suggested physiological sequelae; acute distress reaching hysterical proportions; and hypnotically suggested mutism, blindness, or disturbances of memory. These generally resulted from the inexperience of the clinician involved and complications in the suggestions or metaphors used, rather than the hypnosis itself.

A variety of clinical complications were subsequently reported and reviewed by Hilgard et al. (1961). They cited 15 cases in the literature between 1948 and 1960 in which severe sequelae, including psychotic reactions, have followed the use of hypnosis. Meldman (1960) reported a case of "personality decompensation" following hypnotically based treatment for a flying phobia.

Rosen (1960) expressed concerns about the ineffective management of abreactions and unspecified psychological sequelae. Meares (1961) expressed concerns about the application of hypnosis with the overly dependent personality type, the pre-psychotic schizophrenic patient, the schizoid personality type, and the depressed patient. He highlighted problems that might arise in dealing with acute panic reactions, abreactions, the incomplete removal of non-therapeutic suggestions, difficulties in terminating "trance," and symptom substitution.

Concerns about the potential for the use of hypnosis to encourage the acting out of suicidal ideas in the depressed patient have been the focus of many clinicians and researchers. Cheek and Le Cron (1968) warned against the use of hypnosis with depressed patients. Similarly, Spiegel and Spiegel (1978), Miller (1979), Burrows (1980), Crasilneck and Hall (1985), and Watkins (1987) expressed the same concerns about the potential for hypnotically based treatments encouraging patients to act on suicidal ideation. Such views are not universally accepted, particularly by those who use indirect techniques (Gilligan, 1987; Yapko, 1992) but even here there is the caution about the care needed in selecting appropriate techniques.

Kleinhauz and Beran (1981) reported on a case where "stage hypnosis" appeared to precipitate a severe psychological reaction which resulted in threats to the sufferer's physical health and resulted in several hospital admissions.

Kleinhauz, Dreyfuss, Beran and Azikri (1984) reported a case of "stage hypnosis" being implicated in a participant's psychological distress including anxiety, depression, and "episodic psychotic decompensation" in a subject with pre-existing traumatic experiences.

Kleinhauz and Beran (1984) described two further cases where hypnosis appeared to precipitate depression and antisocial behaviour respectively. Similarly, Haberman (1987) reported a deterioration in psychological functioning when a non-professional practitioner used hypnosis with a patient with pre-existing psychotic difficulties.

In a dental setting, Kleinhauz and Eli (1987) reported four cases of anxiety, depression, post-hypnotic confusion, and cognitive impairment after the clinical use of hypnosis.

In his reviews MacHovec (1986, 1988) reported 86 case examples of adverse effects of hypnosis, with 50% of cases occurring in a clinical setting, 25% in research settings, and 25% as a result of stage performances. He generally concluded that the risk of moderate to severe after-effects of hypnosis is 7% in research and clinical samples, and 15% in relation to stage performances. His review of the complications of hypnosis began by noting under-reporting

of adverse effects of hypnosis in the clinical setting. This may occur because most clinicians, when faced with adverse effects, deal with them utilising their therapeutic skills and hence the complications are short-lived. In his second review of the complications MacHovec (1988) listed 48 adverse symptom reactions reported by participants who had no such previous problems.

Finally, Page and Handley (1990) reported two cases of adverse effects in a research setting.

## **SURVEYS OF PRACTITIONERS**

Averback (1962) surveyed 828 psychiatrists and achieved a response rate of 50%. Two hundred and ten adverse reactions coincident with the use of hypnosis were reported by 120 of these practitioners. The frequent reporting of psychotic decompensation (N = 119) was notably higher than in other studies, but may have resulted from the fact that these difficulties would have been referred to a psychiatrist for treatment whereas other difficulties may not require such professional help.

Levitt and Hershman (1962) obtained responses from 866 of the 2,500 questionnaires mailed to members of the two principal American Societies of Hypnosis. Of the replies, 301 reported "unusual reactions" to hypnotic interventions, with anxiety, panic, depression (9.63%); headache, vomiting, dizziness, fainting (4.98%); crying and hysteria (2.99%); and overt psychoses (1.66%) being the most common. This study had many methodological problems and as a consequence, the results are difficult to interpret.

Judd, Burrows, and Dennerstein (1985), in their survey of 1,086 members of the Australian Society of Hypnosis, reported 88 adverse effects from the 202 responses received. Again the most common of the complications were panic and anxiety (60%), as well as "overdependency" (28%), difficulties in terminating trance (28%), and worsened or precipitated psychoses (15%).

## **SURVEYS OF PARTICIPANTS IN HYPNOSIS RESEARCH**

After testing hypnotic susceptibility using the SHSS scale, Hilgard et al. (1961) found 8% of their 220 subjects reported transient experiences of headaches, dizziness, and confusion.

Hilgard's (1974) study of negative effects in 120 subjects tested for hypnotisability using the SHSS, demonstrated that 16% showed transient negative effects while another 15% experienced negative effects of greater than one hour duration.

Crawford, Hilgard, and MacDonald (1982) compared the negative effects reported after administration of the Harvard Group Scale of Hypnotic Susceptibility (HGSHS) with those of the Stanford Hypnotic Susceptibility Scale (SHSS), which has a greater number of cognitive items. The use of HGSHS resulted in 5% of the 107 subjects reporting negative experiences with only 1% reporting these lasted for more than one hour. In contrast,

the use of SHSS scale resulted in 29% reporting negative effects with 12% of these effects lasting over one hour. There was a tendency for more cognitive distortions to be found in the more hypnotisable subjects. Brentar and Lynn (1989) were not able to confirm this association in a study of 240 subjects using the HGSHS.

Echterling and Emmerling (1987) interviewed 105 students who had attended a "hypnosis stage show." Of these subjects, 33% reported negative experiences, although they were generally transitory.

Misra (1985) reported 16 of 2,000 participants who attended a "stage hypnotist" were referred for negative effects and again these were mostly transitory in nature.

If we consider hypnosis as an altered state of consciousness and a form of persuasive communication (Yapko, 1992), then it is not the hypnosis itself that may cause any such harm, but the communication that is associated with the hypnotic process, the context in which the hypnosis takes place, and the adequacy of the management of the suggestions given (i.e., the appropriateness of suggestions used, individual unwanted associations to the suggestions or state, and failure to adequately complete suggestion removal). As Yapko noted, it is the unintentionally directed associations to other experiences that may be anti-therapeutic.

The risks of adverse effects may be attributed to subjective characteristics such as psychopathology, previous unresolved emotional trauma, and hypnotisability. Adverse effects have also been attributed to practitioner characteristics such as lack of screening for at-risk subjects, misdiagnosis of disorders, ambiguous suggestions, inappropriate interventions, ineffective trance termination, and inadequate debriefing.

## CONCLUSIONS

My review of the clinical and research literature brings me to the following conclusions.

1. There are adverse effects that can arise through the use of hypnosis in clinical and other settings.
2. While most adverse effects are transitory and mildly distressing there is the potential for serious deleterious effects, including psychotic decompensation, depressive and panic reactions, and suicidal acting out.
3. There is no evidence that hypnosis per se is the cause of these deleterious effects. Adverse reactions may arise from pre-existing patient vulnerabilities, therapist inexperience in dealing with psychotherapeutic problems, the use of inappropriate suggestions and metaphors, failure to remove unwanted non-therapeutic suggestions, failure to fully reorientate the patient, and failure to debrief the patient adequately.
4. These problems are more likely to arise if the context does not allow them to be adequately addressed (e.g., in stage performances) or if the



training and experience of the practitioner is not sufficient for them to deal with the problems as they arise (e.g., inadequate training in the areas of hypnosis or psychological functioning).

5. Lay practitioners lacking in the appropriate level of psychological and clinical training are, therefore, more likely to encounter and cause adverse reactions. They are less likely to be able to respond to them therapeutically and ensure the patient's recovery.
6. The practice of hypnosis requires the demonstration of a level of knowledge, skills, and supervised training in therapy approaches relevant to the problem being addressed. Most professions require their members to offer treatment only in those fields in which they have appropriate training. The protection of the patient requires this limitation be maintained.
7. Adequate training and accreditation procedures need to be in place to ensure the patient is not subject to treatment approaches of which the practitioner does not have adequate understanding.
8. The use of hypnosis in contexts that pose the greatest dangers ought to be controlled or disallowed for the public protection. Despite the claims to the contrary, there are a significant number of reports of serious sequelae following the use of hypnosis on stage.

The context within which the state is induced may present some problems. If any alteration of cognitive processing interferes with what a person may need to do to maintain their safety, then it may be harmful.

Inappropriate associations that facilitate the hypnotic state or failure to return to the usual mode of cognitive functioning may potentially pose a danger if the person is in a context that needs full attention. These effects are not a consequence of the hypnosis per se, but a failure of awareness of cues that may facilitate the hypnotic alteration of attention in some potentially dangerous context. Similarly, failure to return the subject to the usual state of cognitive functioning is not a problem of hypnosis but of its use.

## **WHAT ARE THE CURRENT CONTROLS?**

A number of countries have seen fit to pass legislative controls concerning the use of hypnosis but the extent of these controls is variable. The United Kingdom, Israel, Brazil, some states of the United States, and some provinces of Canada currently have acts that limit the use of hypnosis in a variety of ways.

In Australia, there are a variety of approaches to the legislative control of the practice of hypnosis. New South Wales has no specific controls and the buyer-beware principle applies to clinical practice. Similarly, in the Northern Territory there is no legislation. In all other states, some controls apply but they are variable in their scope and their enforcement. These acts are summarised below.

**Jurisdiction: Victoria** (until such time as the proclamation of the *Psychologists Registration Act (1987)* occurs).

*Title of the Act: Psychological Practices Act (1965).*

*Clinical Hypnosis:* The Act does not apply to medical practitioners, nor to ministers of religion who may, therefore, use hypnosis, if appropriate, within that context.

*Conditions:* Hypnosis must not be practised by any person under the age of 21 years. Psychologists and dentists must seek the permission of the Victorian Psychological Council to practise hypnosis. In the case of psychologists, hypnosis must be carried out under the supervision of a medical practitioner, (interpreted by the Council as the patient being referred by a medical practitioner).

*Other Practitioners:* Not permitted without the permission of the Victorian Psychological Council. (In practice this has only allowed a "grandfather" interpretation in which a limited number of other practitioners, who prior to 1965 practised hypnosis in the treatment context, were allowed to continue practice.)

*Stage Hypnosis:* Hypnosis not permitted for purposes of entertainment without the written permission of the Victorian Psychological Council.

*Comments:* This Act will cease to operate once the *Psychologists' Registration Act (1987)* is proclaimed (expected in mid-1994). The lack of adequate requirements to demonstrate training and expertise even amongst professions, in the present Act, is a concern. Unequal controls applying to the three professions are unacceptable. Medical referral requirement is likewise unjustifiable and relevant professional standards and restrictions should apply. The poor definition of hypnosis under this Act has resulted in difficulty in obtaining prosecutions under the restrictions of hypnosis in the field of "entertainment."

**Jurisdiction: Victoria after 1994**

*Title of the Act: Psychologists' Registration Act (1987).*

*Clinical Hypnosis:* Clinical hypnosis may be carried out by any registered psychologist, medical practitioner, or dentist. There is no requirement for referral, nor is there any need for a member of these three professions to seek the approval of the Board.

*Conditions:* No conditions apply with respect to demonstrating expertise or training and these controls *cease two years after the proclamation* of this Act. After this time, unless there is a new Act (see later comments), there will be no control over the practice of clinical hypnosis or in relation to other contexts. There are no age restrictions applying to the practice of hypnosis.

*Other Practitioners:* Other practitioners who were previously able to practise as a result of the "grandfather clause" of the *Psychological Practices Act (1965)* may continue (it is not clear whether any remain in practice). Others may apply to the Registration Board for permission, but no indications are given as to the criteria on which this might be considered.

*Stage Hypnosis:* Hypnosis in the context of "entertainment" requires the permission of the Board, otherwise an offence is committed.

*Comments:* Because this Act does not include the redundant 1965 Act definition or any definition of hypnosis, the potential for it being used to protect the public from lay practitioners or “entertainers” is greater. The Society is seeking the adoption of a “Hypnosis Registration Act” to come into force after the two-year “sunset clause” included in the *Psychologists’ Registration Act (1987)* expires. It may be difficult to achieve the adoption of this proposed Act in Victoria without other states similarly agreeing to standardise the qualifications required to practise. The states and federal governments have an agreement to move to uniform accreditation criteria.

**Jurisdiction: South Australia**

*Title of the Act: Psychological Practices Act (1973).*

*Clinical Hypnosis:* Clinical hypnosis may be carried out by any registered psychologist, legally qualified medical practitioner, or dentist, if the dentist has obtained the permission of the South Australian Psychological Board.

*Conditions:* No conditions apply with respect to demonstrating expertise or training. No age restrictions are included and referral is not required.

*Other Practitioners:* Those who qualify under a “grandfather clause” are permitted to continue practice. Others may seek permission of the Board to practise.

*Stage Hypnosis:* The Act does not specifically discuss the issue of “entertainment,” but presumably prosecutions could be sought as stage performers are not one of the prescribed groups permitted to practise.

*Comments:* This Act does not have a definition of hypnosis which may be an advantage. The lack of requirements that any of our professions demonstrate training and expertise is a concern. A new Act has been proposed that addresses some of these issues.

**Jurisdiction: Tasmania**

*Title of the Act: Psychologists’ Registration Act (1976).*

*Clinical Hypnosis:* The Act permits legally qualified medical practitioners, dentists, and registered psychologists to practise hypnosis in their professional field, without the permission of the Board.

*Conditions:* Must not be practised by any person under the age of 21 years. No requirements concerning referral by a medical practitioner apply.

*Other Practitioners:* Not permitted without the permission of the Psychologists’ Registration Board.

*Stage Hypnosis:* Not permitted to be used for purposes of entertainment without the written permission of the Psychologists’ Registration Board. If permission is given, hypnosis must not be used with those under the age of 18 years.

*Comments:* This Act uses an inadequate definition of hypnosis similar to that of the Victorian *Psychological Practices Act (1965)*. Lack of adequate requirements to demonstrate training and expertise even amongst professions is a concern. Under this Act, it is likely that similar difficulties may be encountered in obtaining a prosecution under the restrictions of hypnosis in the field of “entertainment.”

**Jurisdiction: Western Australia**

*Title of the Act: Psychologists' Registration Act (1976).*

*Clinical Hypnosis:* Registered psychologists and legally qualified dentists may practise hypnosis within their professional field, without the permission of the Board. Medical practitioners are exempt from the controls of the Act and hence may similarly practise hypnosis.

*Conditions:* No conditions apply other than those detailed above.

*Other Practitioners:* A "grandfather clause" allows those who earned their income principally from the practice of hypnosis to continue to practise under the conditions laid down by the Board. Other applications to practise can be considered, with the Board having the power to specify the rules under which such permission may be granted.

*Stage Hypnosis:* Not mentioned, but presumably the general specifications as to who may practise hypnosis apply.

*Comments:* This act makes reference to, but is not bound by, the ethical standards of the Western Australian Society of Medical Hypnosis (now part of the Western Australian Branch of the Australian Society of Hypnosis) and the International Society of Hypnosis.

**Jurisdiction: Queensland**

*Title of the Act: Psychologists' Registration Act (1977).*

*Clinical Hypnosis:* Registered medical practitioners, psychologists, and legally qualified dentists may practise hypnosis within their professional field, without the permission of the Board.

*Conditions:* No conditions apply other than those detailed above.

*Other Practitioners:* A "grandfather clause" allows those who earned their income principally from the practice of hypnosis to continue to practise under the conditions laid down by the Board. Other applications to practise can be considered with the Board having the power to specify the rules under which such permission may be granted. The current review of these rules has led to the specification of the process of examination (written examination, case histories, oral examination and supervision requirements) by which others, including other health-related professions, may receive the Board's permission to practice.

*Stage Hypnosis:* Stage hypnosis is not permitted under the Act, but the definition of hypnosis in the Act does not make prosecution of entertainers likely.

*Comments:* This act suffers from the same inadequacies as the Victorian *Psychological Practices Act (1965)*, making control over the actual practice of hypnosis extremely difficult. The act is currently being reviewed.

**CONCLUSIONS**

1. The literature supports the belief that hypnosis can have some adverse effects, although they are generally transitory and easily managed by a skilled clinician. More serious adverse reactions may occur, especially if the subject has a pre-existing potential for psychotic decompensation,

or if the expertise of the practitioner or the context of the hypnosis is inappropriate. The application of hypnosis with depressed patients or in the treatment of panic states and unexpected abreactions may depend on the expertise of the clinician concerned.

2. Applications of hypnosis therapeutically should, in order to protect the subject from these consequences, be restricted to appropriately trained and accredited professionals, who use hypnosis only within their area of professional practice.
3. Hypnosis used in the entertainment context is fraught with many risks and the lack of adequate screening, follow-up, and debriefing is a major concern. The failure to de-hypnotise highly suggestible members of the audience, together with inadequate suggestion removal, poses significant risks. On this basis, and for the image of therapeutic hypnosis, its practice in relation to "entertainment" ought not to be sanctioned.
4. The current legislative controls are variable in their adequacy, from the non-existent through the inappropriate and unenforceable to the barely adequate. The enforcement of these controls varies according to the determination and enthusiasm of the regulating board or council.
5. The reasons for our concerns about the need for legal controls over hypnotic practice certainly have implications for professional practice. However, our concerns are based on the wish to avoid the adverse effects of hypnosis that may accompany its use, particularly in non-therapeutic settings. While wishing to ensure the reputation of hypnosis as a therapeutic approach is not damaged by its non-professional use, our primary concern must be the prevention of public harm.

It is in the interests of the safe professional use of hypnosis that all practitioners support every effort being made to have adequate legislation enacted.

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