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Key Concepts in Hypnosis

Hypnosis is inextricably tied to the false memory problem, whether its use is formal or disguised. FMSF Scientific Advisor Campbell Perry, Ph.D. has written this section to provide readers with the key concepts in hypnosis. Dr. Perry is Professor Emeritus of Psychology at Concordia University in Montreal. He has published widely in the area of hypnosis.

The website of the [International Journal of Clinical and Experimental Hypnosis](#) and the [research database](#) provided by the Society for Clinical and Experimental Hypnosis may interest readers wishing to explore the area of hypnosis further.

Key Concepts in Hypnosis **Campbell Perry, Ph.D.**

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The final responsibility for all opinions expressed in this document is my own.

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What is hypnosis?

Hypnosis involves a person's ability to set aside critical judgment without relinquishing it completely, and to engage in make-believe and fantasy (Gill & Brenman, 1959; E. R. Hilgard, 1977). For some people this make-believe may be so vivid and intense that they have trouble differentiating it from reality. Indeed, they may not be able to do so. It should be emphasized that the experience of hypnosis has very little to do with the abilities of the hypnotist, and is mainly a matter of abilities of the person hypnotized. The ability to conduct a hypnotic induction is acquired easily and rapidly by an individual who has at least moderate interpersonal skills, and who is able to establish a relationship of trust and an appearance of competence.

Hypnosis in itself is not a science; its phenomena, though, have proven to be highly amenable to experimental research employing the methodology and procedures of scientific enquiry. The ability to hypnotize does not qualify a person to treat others; for that, a post-graduate degree in psychiatry or clinical psychology allied to a solid grounding in hypnotic phenomena

are required. Some more detailed suggestions are provided in the section called [How can a person find a qualified clinical practitioner of hypnosis?](#)

What are the main historical events of hypnosis?

Hypnosis has a long and rich history (Gauld, 1992; Laurence & Perry, 1988), dating from the late 18th Century in Paris. During that period, Franz Anton Mesmer gained astonishing popular recognition for what he called Animal Magnetism (the first of several metaphors for what is now called hypnosis). Mesmer believed that there is an invisible animal magnetic force or fluid in the atmosphere which he could harness, store in his body, and transmit to physically ill patients with curative effects.

What is remarkable about Mesmer is that although the historical records of his practice are not always clear, Mesmer obtained major improvements and occasionally complete cures that other medical professionals of his epoch were not able to obtain. This success led him to conclude, erroneously, that Animal Magnetism exists; we now know, however, that the various non-specific placebo factors that are present in healing situations may have been the effective ingredients in his treatment successes. Elements such as hope for a cure or alleviation and faith and trust in the magnetist, and in magnetism, are all likely to have weighed in, just as they do in a variety of healing contexts today.

In 1784, A Royal Commission of Inquiry into Animal Magnetism was established. It was headed by Benjamin Franklin, and included some of the leading scientists of the day such as Lavoisier, the chemist, and Guillotine, the inventor. It performed some quite sophisticated experiments on magnetic phenomena. With the magnetically "adept" person separated from the magnetist by a paper screen so that they could not see each other, the Commissioners found that the patient frequently showed magnetic effects when the magnetist was not magnetizing, and did not show these effects on other occasions when he was. The Commission concluded (correctly) that animal magnetism did not exist, and (incorrectly) that its non-existence meant that it could not have curative effects.

In the true traditions of science, however, the commission provided an alternative explanation of magnetic phenomena, part of which suggested a way in which an ostensibly non-existent entity could, in fact, have curative effects. It concluded that the effects observed were the product of imagination, imitation and touch, and that the main contributing factor was imagination. As will be seen later, imagination still has considerable currency in much theorizing about hypnosis; it is now considered central to understanding the manner in which hypnosis quite often alleviates a variety of medical difficulties, in situations such as clinical pain, where drugs and/or surgery have been ineffective (Melzack & Perry, 1975).

Two other investigators of this period made significant contributions to the understanding of what is now called hypnosis. The Marquis de Puységur renamed it artificial somnambulism, and placed much emphasis on the notion that magnetic phenomena were most likely to be elicited under conditions of what he called "exclusive rapport" between hypnotist and hypnotized person. The Abbe Jose Custodia di Faria called it lucid sleep, and drew attention to the observation that between 16-20% of the population was highly responsive to it (an estimate not unlike current data on high levels of hypnotic responsivity). Others, including Mesmer, had reported on the differential nature of response to what is now known as hypnosis, but Faria was the first to emphasize it and to make it the cornerstone of his position.

The term "hypnosis" was coined by James Braid, a Manchester surgeon, in his book of 1843. Here he was following the sleep metaphors proposed by Puységur and Faria, since the term comes from the Greek hypnosis: to sleep. At a superficial level, this is a plausible deduction given that, as Faria observed, such phenomena as sleep walking and talking appear to be duplicated in hypnosis. It was not until the 1950s, with the advent of the technology of the electroencephalogram (EEG) that the sleep metaphor was discarded. The EEG of hypnosis is formally indistinguishable from a pattern of being relaxed, alert with eyes closed. By contrast, the EEG of sleep consists of four distinct polygraph defined stages that run in approximately 90-minute cycles of progressively less depth throughout the night (Aserinsky & Kleitman, 1953).

For much of the 19th Century, another view of hypnosis gradually took hold. This is the belief that hypnosis is a matter of a person's degree of suggestibility. Unfortunately, this particular conceptualization carries pejorative overtones, implying that response to hypnosis is a matter of gullibility and/or feeble will. Suggestibility theory makes little logical sense, being based upon the observation that because a person responds to a number of suggestions, s/he must be suggestible.

The sleep metaphor came to be reconciled, to a degree, with suggestibility theory in the latter part of the 19th Century in France. A.A. Liebeault saw hypnosis as "artificial sleep" and as indistinguishable from nocturnal sleep. He also viewed suggestion as essential in actuating the hypnotic process, in which the hypnotized person became an automaton, unable to

resist the demands of the hypnotist.

Towards the end of the 19th Century, two "schools" of hypnosis emerged in France. Each had views that were frequently opposed diametrically. Hippolyte Bernheim, much influenced by Liebeault, headed a "school" at the University of Nancy, and argued that hypnosis was initiated by suggestion and explained by suggestibility. By contrast, Jean-Martin Charcot at La Salpetriere Hospital in Paris, one of the foremost neurologists of his day, argued that hypnosis is a physio-pathological condition allied to hysteria. At around this time, legal cases involving evidence derived from hypnosis began to be heard by French courts, and both Charcot and Bernheim became deeply involved in the controversy that these legal proceedings generated.

The effect of these legal battles for the study of hypnosis was disastrous in the short term. Not only did Charcot and Bernheim hold almost diametrically opposed views on many issues; both, also, were in error on some of them. Professional interest in hypnosis waned towards the beginning of the 20th Century, as people in the field turned away from this corrosive legal battle, and towards the distinctive views and approach of Sigmund Freud.

*For the first three decades of the 20th Century, interest in hypnosis remained in decline, only to be revived by Clark L. Hull, whose 1933 book entitled *Hypnosis and suggestibility: An experimental approach* was instrumental in rekindling interest in the topic. This renewal of interest was short-lived, however; Hull was forced to abandon the study of hypnosis and to turn his attention to learning theory. Two apocryphal stories exist on why this happened. One is a misguided concern that hypnosis threatened the chastities of female students at his university. An alternative account is that a student who was working at Hull's lab hypnotized another student, but did not evaluate post-hypnosis alertness. The student left and was hit by a car while crossing the street. The parents threatened to sue Yale University (or did sue it) and the lab was closed. Whatever the reason, the field of hypnosis lost one of its most talented and prolific researchers at a time when it could least afford it.*

World War II, however, provided an unexpected reprieve. In the heat of battle, field hospitals often ran short of the drugs needed to treat wounded soldiers. Under often appalling conditions, a small group of clinicians of hypnosis were able to provide pain relief and alleviation of the suffering of their often severely injured patient. Some of these clinicians banded together after the war ended to form the Society for Clinical and Experimental Hypnosis (SCEH); it held its first meeting in 1949. Unfortunately, as a result of some major disputes on clinical issues within SCEH, some clinicians, spearheaded by Milton Erickson, went on to form the American Society of Clinical Hypnosis (ASCH) in 1957.

The period between 1960 and 1990 is likely to be seen by future historians as halcyon days for hypnosis. During this period, three major hypnosis research laboratories developed in the United States. One was at Stanford University under the direction of Ernest and Josephine Hilgard. A second one was at the University of Pennsylvania (after a brief inaugural period at Harvard University) under the guidance of Martin T. Orne, Emily Carota Orne and (in later years) David F. Dinges. A third one was at Medfield Hospital in Massachusetts under the auspices of Theodore C. Barber. Unfortunately, the Stanford and Medfield laboratories are no more; by contrast the Philadelphia Laboratory continues to thrive.

These three laboratories had a profound effect on younger clinicians and researchers who entered the field of hypnosis during this period; indeed, many of them received some of their doctoral and/or post-doctoral training at either Stanford, Pennsylvania or Medfield. In addition, strong national societies of hypnosis sprang up in many countries, and, gradually, some international structures to link them. With the ease and speed of travel provided by the aviation industry, the study of hypnosis became international in a manner hitherto not envisaged. The upshot of these developments is that, for future investigators of the 21st Century, there exists a solid empirical, clinical and forensic base upon which to build. But there are lessons from Nancy and Salpetriere that must be remembered -- always.

Is the term "hypnosis" a metaphor?

The history of hypnosis has something important to say about the scientific endeavor in general. One way of looking at how Science progresses is through theories changing over time. And a theory may be thought of as a metaphor, or an as if construct. A metaphor is chosen to help elucidate or explain a phenomenon that is not understood, in terms of other things that seem to be better understood. One metaphor gets replaced by another one that seems a better fit of the facts.

Thus, Mesmer can be seen as embracing the metaphor of Animal Magnetism and as arguing that it is as if the behaviors he observed were the product of this invisible force that he could harness, accumulate in his body, and transfer to sick people. Faria with lucid sleep, Puysegur with artificial somnambulism, and Braid with hypnosis were all saying that it was as if the

magnetized person was in a state akin to nocturnal sleep. Liebeault and Bernheim adopted the metaphor of suggestibility for precisely the same reason, though their logic was a little askew; they maintained that since suggestion is an essential ingredient of the hypnotic process, suggestibility must be the key as if formulation for understanding it. The same can be said of Charcot in seeking to link hypnosis with hysteria, since many of the behaviors found in hysteria could be reproduced in hypnosis -- it was to him as if hypnosis followed processes similar to those he had observed in this particular class of patients.

It remains to be seen whether current accounts of hypnosis that are couched in terms of a person being involved in imagination will suffer a similar fate and come to be seen as obsolete, as if formulations. It may happen, but the term "hypnosis" is unlikely to be discarded; it is a soothing metaphor, and the fact of its near universal adoption since Braid coined it more than 150 years ago ensures a certain degree of continuity with the past. It provides, also, some safeguard that the phenomenon that is under discussion now is what various investigators were observing at an earlier time.

Can hypnosis be feigned?

Although the behavior observed in hypnosis can be dramatic and compelling at times, it can be simulated by individuals who have little of the ability to be hypnotized. Low hypnotizables are chosen for the task of simulation because there is no likelihood of them becoming hypnotized inadvertently. They are instructed that intelligent people can fake hypnosis, and are told, truthfully, that the person performing the hypnosis is blind as to who is, and is not, hypnotized. In addition, they are told that the hypnotist will terminate the induction if s/he suspects simulation. Importantly, simulators are not given any training on how to enact this role. If they ask, as many do, they are told simply that they are to try to pick up any available implicit cues in order to determine what the demand characteristics (Orne, 1959) of the situation are. That is, they are asked to figure out what the hypnotist wants, and then to respond accordingly.

Some investigators in the field believe that hypnosis is little more than a form of behavioral compliance. If it were true, it would make the study of hypnosis substantially less interesting. Retrospective subjective reports, however, indicate that more than behavioral compliance is involved. For instance, a common hypnotic item is the suggestion that an arm is stiff and rigid, and impossible to bend no matter how hard the hypnotized person tries. It is very difficult, on the sole basis of observing the behavior, to differentiate a person who truly believes that the arm is impossible to bend at the elbow, no matter how hard s/he tries, from a person who complies with the suggestion, in full knowledge that s/he can bend the arm.

Reports of hypnotized and simulating subjects reveal that hypnosis involves, basically, subjective alterations in perception, mood and memory (Orne, 1980); this means that there is a qualitative difference between persons who report that a suggested subjective alteration was experienced as "happening" involuntarily to them, as opposed to those who report it as something that they "did" actively and voluntarily. It is from subjective reports, rather than from behavioral manifestations, that a differentiation of voluntary compliance from the involuntary experience of hypnosis becomes possible. This, however, is not an all-or-nothing distinction; some behavior in hypnosis is voluntary.

For instance, a willingness to cooperate, and to experience subjective alterations are major prerequisites of hypnotic response. This issue is addressed in more detail in the section Are high hypnotizables suggestible? In conclusion, the comparison of hypnotized and simulating individuals points to a fundamental differentiating characteristic: the responses of simulators tend to be based upon logic, while those of hypnotized people tend to be grounded in fantasy (Orne, 1979).

To what extent is a person able to experience hypnosis?

Hypnotic susceptibility, hypnotic ability, hypnotizability and hypnotic responsivity are terms that are used interchangeably in the scientific literature on hypnosis. They refer, descriptively, to the extent to which a person is able to experience hypnosis. Hypnotic susceptibility is a differential phenomenon; research dating back to over a century ago indicates that there are individual differences in this ability. Despite numerous attempts to modify hypnotic ability by training low responsive individuals to become highly responsive (Spanos, 1986), the evidence indicates that these individual differences are stable and enduring.

Studies have found, repeatedly, that approximately 10-15% of the population is highly responsive to hypnosis; that is, able to experience the more classical phenomena of hypnosis such as age regression, analgesia (pain reduction), positive and negative hallucinations, and post hypnotic amnesia. An additional 10-15% is unresponsive, or minimally responsive to hypnosis; these individuals are unable to experience even mild subjective alterations, such as the suggestion (experienced by approximately

90% of the population) that the arm is light and weightless and is floating towards the forehead of its own accord, as if it were attached to a brightly colored helium balloon. The remaining majority of 70-80% of the population is moderately responsive to hypnosis; they can experience easy, and in some cases, moderately difficult hypnotic items, but at a certain cut-off point they are unable to respond further. Most hypnotizability scales (next section) consist of items that become progressively more difficult.

How can hypnotic susceptibility be measured?

Experimental attempts to measure hypnotic susceptibility began as early as the 1930s; the most commonly accepted measuring instruments were developed during the late 1950s at Stanford University. These are the Stanford Hypnotic Susceptibility Scales: Form A, B, and C (SHSS: A, B, C) developed by Andre M. Weitzenhoffer and Ernest R. Hilgard (1959; 1962) and the Harvard Group Scale of Hypnotic Susceptibility: Form A (HGSHS: A) developed by Ronald Shor and Emily Carota Orne (1962); it is an adaptation of SHSS: A for administration to small groups.

All follow the same principle of test construction. They each consist of 12 items of progressively greater item difficulty (as defined, psychometrically, by the percentage of subjects in a normative sample that reports experiencing each particular item). The initial items are ones on which 80-90% of the normative sample report experiencing, the later ones are sufficiently difficult that only a minority of 10-20% experience them. In addition, SHSS:C is said to have more "top" to it than the other measures; that is, it consists of fewer easy items, and contains more difficult ones drawn from the 10-40% difficulty level (Perry, Nadon & Button, 1992).

Are high hypnotizables suggestible?

During the latter part of the 19th Century and for several decades into the 20th Century, the prevailing view among investigators of hypnosis was that it can best be understood in terms of suggestibility. At a descriptive level this may be true, but as an explanation, suggestibility theory depends upon the far from useful observation that a person who responds to a gamut of hypnotic items, ranging from very easy to very difficult is, ipso facto, suggestible. Logically, this is a circular argument, the form of which can be stated as follows:

Question: Why did a particular person respond to a number of hypnotic items?

Answer: Because s/he is suggestible.

Question: How do you know that s/he is suggestible?

Answer: Because that person responded to a number of hypnotic items.

Quite a few concepts in Psychology are used in a comparably circular fashion. Instinct is a thoroughly respectable term when used descriptively, but far too often it is used to explain what it describes. For instance, weaver birds build a distinctively shaped nest, and the evidence is that they do this when raised from birth in isolation from their parents. This is clear evidence that their nest-building behavior is instinctive, rather than learned. It is accurate descriptively to say that weaver birds have a nest-building instinct, but a pseudo-explanation to regard this empirically established instinct as explaining this behavior (E. R. Hilgard, 1971). For that, professionals trained in such fields as genetics and biochemistry appear to be more likely to provide the requisite explanation by examining what is built into the body of the bird.

By the same token, it is correct to say that people who respond positively to a hypnotic procedure are suggestible -- but only at the descriptive level. Suggestibility describes what they do; it does not explain why they do it. To understand why they do what they do, a rationale needs to be developed which differentiates the people who respond to most hypnotic items, regardless of difficulty, from those who respond minimally, if at all. Returning to weaver birds, it is true that they build distinctively shaped nests and that this behavior suggests the existence of a nest-building instinct. The mechanism that underlies this instinct needs to be documented independently, so as to avoid circular reasoning. By an identical logic, the same can be said about the mechanisms that underlie response to hypnosis, and about high and low levels of this response to it.

Is hypnosis a form of placebo?

Responsivity to a placebo, or sugar pill, is as valid an operational measure of suggestibility as one is likely to find. If hypnosis is no more than a matter of suggestibility, there should be no difference between response in hypnosis as opposed to response in a placebo condition, though one might expect differences between high and low hypnotizables. McGlashan, Evans and Orne

(1969) sought to examine this question by comparing groups of high and low hypnotizables in conditions of hypnotic analgesia and placebo, in a study of response to ischemic pain. In both analgesia and placebo, subjects had a tourniquet placed on a forearm while pumping water from one container to another. This procedure milks the blood from the veins of that arm, and yields some quite elegant measures of work and effort, since the longer that an experimental subject can continue to pump water, the more one can say that his (all subjects were men) performance is unhindered by the rapidly mounting pain of ischemia.

The results were striking. Low hypnotizables showed a mild pain reduction in both the hypnotic analgesia and placebo conditions. By contrast, high hypnotizables showed substantial pain reduction in hypnotic analgesia, and a slight pain increase in the placebo condition; their performance in placebo did not differ statistically from that of the low hypnotizables in the same condition. This finding is diagrammed in Figure 1. From this, it can be concluded that the mechanisms underlying hypnotic response are formally distinguishable from suggestibility.

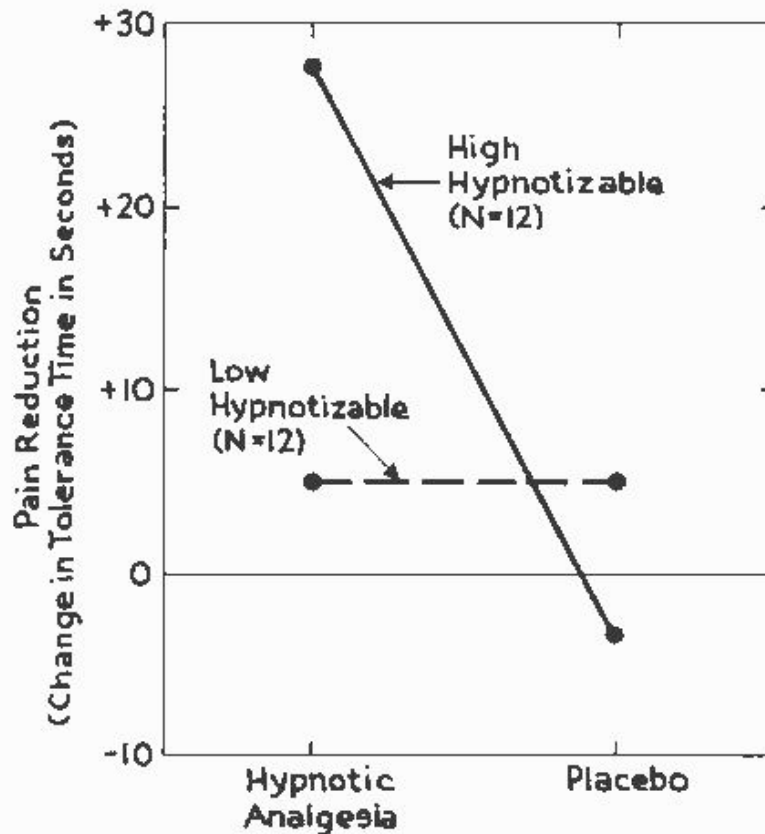


Figure 1. Differential effect of hypnotic analgesia and placebo in experimental subjects of high and low hypnotizability (compiled by Hilgard & Hilgard (1975), from the data of McGlashan, Evans & Orne (1969)).

Twenty years passed before an attempt was made to replicate this finding. Spanos, Perlino and Robertson (1989) reported two studies in which pain reduction was measured by a strain gauge. This involved placing a weight of 2300 grams on the first phalanx of a finger. The placebo was different, also. It was described as a "topical anesthetic," and was a solution of three parts colored water to one part ethyl alcohol. The latter produces sensations of cooling and mild tingling, and was used to communicate to the experimental subjects that the anesthetic was having the desired effect.

High and low hypnotizables were compared across the two studies in various combinations of baseline, placebo and control conditions. It was found that, in both studies, high hypnotizables showed significantly greater pain reduction in hypnosis as compared to both baseline and placebo conditions. The study is important since it is a rare instance of hetero-method replication; that is, Spanos et al. obtained the same finding as McGlashan et al., despite major differences in the pain stimulus, the placebo employed, and the way in which they measured responsivity to hypnosis. This point that hypnotizability is

something distinct from suggestibility (as indexed by placebo response) has been confirmed independently, also, by Gudjonsson (1987) using the suggestibility scale that he developed.

What role does imagination play in hypnosis?

One of the earliest attempts to clarify the mechanism(s) underlying individual differences in hypnotizability centers around the idea that the hypnotized person deploys his/her skills of imagination to the point of becoming deeply involved in the ongoing fantasy activity of a hypnotic induction. This emphasis dates from the Benjamin Franklin Commission of 1784. Most of the major contemporary investigators of hypnosis allocate a role to fantasy and imagination in the hypnotic process; perhaps the strongest emphasis on such processes is to be found in the work of Josephine Hilgard (1970/79), J. Philip Sutcliffe (1961) and that of Theodore Sarbin and William C. Coe (1972).

Josephine Hilgard coined the term imaginative involvement to highlight this particular position. In similar vein, Sutcliffe emphasized delusion in a descriptive sense to point to the manner in which fantasy may take on reality value for some hypnotized individuals, and becomes accepted by them as having happened in actuality. Likewise, Theodore Sarbin and William Coe emphasized the role of imaginings that become believable. In each case, the thrust is in terms of imaginings that become so vivid and intense that the person in hypnosis may not be able to distinguish them from reality, and may come to believe that they are actual occurrences. This position is aptly summarized by Auke Tellegen (1978/79). He wrote: "It is the ability to represent suggested events and states imaginatively and enactively in such a manner that they are experienced as real."

There is research support for this position. A study conducted by Tellegen & Atkinson (1974) has demonstrated that hypnotic responsivity is related to the ability to become absorbed in imagining such things as the setting of the sun, or the smell of ripe oranges. Further, data collected by Cheryl Wilson and Theodore X. Barber (1982) has identified a subset of high hypnotizables whom they characterize as fantasy "addicts;" that is, as individuals who spend as many of their waking hours as possible engaged in fantasy and imagination.

A number of other theorists of hypnosis have emphasized the role of fantasy and imagination, but have placed less stress on the role of absorption, though they all agree that reality testing may be suspended and belief may be altered. Ernest Hilgard (1977) has emphasized dissociation, and views hypnosis as involving multiple, overlapping systems of cognitive control, some of which may not always be available to conscious awareness and which may tap into fantasy processes. Martin T. Orne (1980) views hypnosis as involving alterations, even distortions, of perception, mood and memory. In similar vein, Judith Rhue and Steven J. Lynn (1989) view highly hypnotizable individuals as highly prone to fantasy.

Nicholas Spanos and Theodore X. Barber (1974) conceptualize it as "thinking along with and experiencing suggestion related imaginings." Unlike other investigators, their emphasis is upon hypnotic behavior as being entirely voluntary and rational, even though hypnotic behavior, at least among high hypnotizables, appears to be an admixture of voluntary and involuntary behavior, in which rational and non-rational components are fused.

At the same time, as Theodore X. Barber (1969) emphasized, positive motivations, favorable attitudes, and positive beliefs about hypnosis (that being hypnotized is an enjoyable and safe activity) also play an important role in determining hypnotic outcomes. While this is certainly so, such social psychological influences are of little consequence to the experience of hypnosis if the person lacks such requisite abilities as imagination and absorption; by the same token, a person with these requisite abilities will not respond to a hypnotic induction procedure if s/he lacks the necessary motives, attitudes and beliefs.

For instance, for most of the 19th Century, post hypnotic amnesia was reported by investigators of the period as occurring spontaneously; this appears to have stemmed from the shared beliefs of the hypnotist and of the hypnotized person that this was the nature of the phenomenon. But then, as now, it was a relatively small percentage of hypnotized individuals who responded in this manner. In other words, only those individuals who had the requisite ability responded in a manner consonant with the prevailing belief of the period.

How does hypnosis affect memory?

Experimental data indicate that hypnosis has three main effects upon memory. (1) Hypnosis increases productivity, but most of the new information is in error; (2) it increases confidence for both correct and incorrect "novel" remembrances; (3) these

increases in productivity and confidence are found at all levels of hypnotizability, but these effects are most pronounced in high hypnotizables in hypnosis (as compared to when they are assigned to an imagination or a repeated recall condition), and as compared to low hypnotizables who receive either hypnosis, imagination and repeated recall instructions (Nogrady, McConkey & Perry, 1985; Orne, Soskis, Dinges, Orne & Tonry, 1985).

Hypnosis can result in confabulation. This is the tendency to confuse fantasy as fact. Again, as was emphasized earlier, the possibility that novel information elicited in hypnosis may be confabulated must be evaluated -- always. It is possible that such new information is true, but as equally, it could be a lie, it could be confabulated, or it could be pseudo-memory that is manufactured in response to the demands of the hypnotic situation. These four alternatives -- truth, lie, confabulation or pseudo-memory -- were emphasized by French forensic investigators of over a century ago (Laurence & Perry, 1988), and each of them, still, requires rigorous assessment.

Hypnotic hypermnesia effect

"Hypermnesia" refers to an abnormally vivid or complete memory. Hypnotic hypermnesia is the belief that hypnosis enhances accurate memory for events that a person is initially unable to remember. In actuality, there is little evidence favoring the hypnotic hypermnesia effect. Although people may produce more information with the use of hypnosis, it is not necessarily accurate. Given that the processes underlying response to hypnosis appear to implicate fantasy and imagination, any novel material elicited in hypnosis needs to be corroborated by independent means. This is particularly so when hypnosis is employed as a part of a police investigation designed to elicit additional leads. Uncorroborated, hypnotically elicited memories can, all too easily, lead to the wrongful imprisonment of innocent people.

Post hypnotic amnesia

Post hypnotic amnesia is the failure to remember most, if not all of the events occurring in hypnosis, until a pre-arranged signal to recall them is administered. This phenomenon is confined to the top 10-15% of the population, and, typically, these individuals remember mere fragments of what transpired during the preceding period of hypnosis. They may, for instance, recall writing their name, their age, and the date, but not that this request was made within the context of being hypnotically age regressed to childhood. While some high hypnotizables have a "blanket" amnesia for the events of hypnosis, this is more typical of low hypnotizables asked to simulate hypnosis (Orne, 1979). Usually, the response of simulators to this and other hypnotic items is to respond in terms of the perceived demands of the situation. They tend to interpret an amnesia suggestion as meaning that they cannot remember anything at all until they receive the signal to reverse the amnesia.

This reversibility of post-hypnotic amnesia distinguishes it from amnesias of organic origin, such as from a blow to the head. While evidence suggests that memories based upon a retrograde amnesia (that is, one resulting from trauma of either a psychological or physical character) may become available eventually, the retrieval process is, ordinarily, slow and laborious. By contrast, the reversal of hypnotically suggested amnesias is effected by a simple suggestion that the person "can now remember everything."

What is the relevance of "dissociation" to hypnosis?

Another characteristic of the hypnotizable person that has long been implicated in the hypnotic process is the ability to dissociate. The problem with this particular concept is that it is part of the intellectual baggage that was inherited from the 19th Century, and it is a term that has more than one meaning. Sometimes the term is used to mean the ability to perform two tasks at once; at other times, it points to the ability to focus upon one activity to the exclusion of all other elements in a situation (in which case it may be formally indistinguishable from absorption).

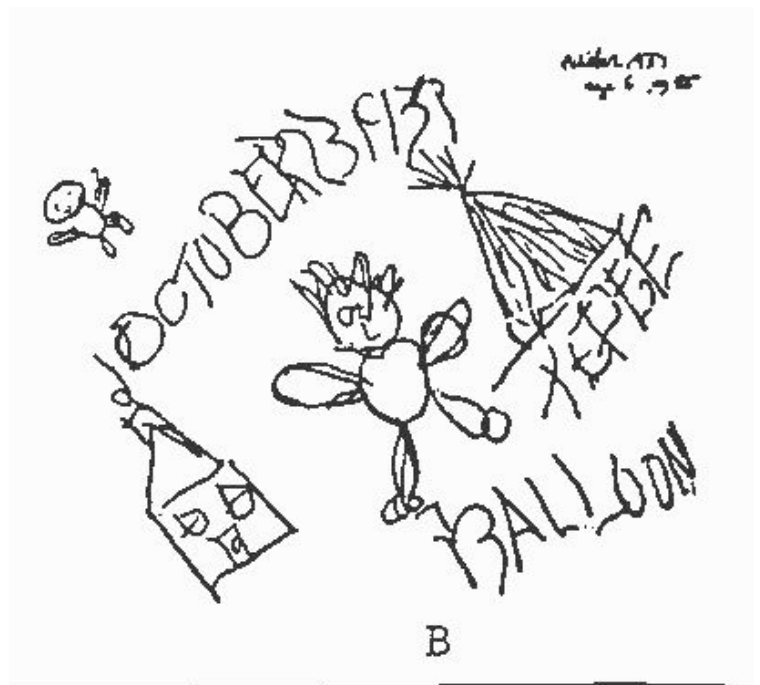
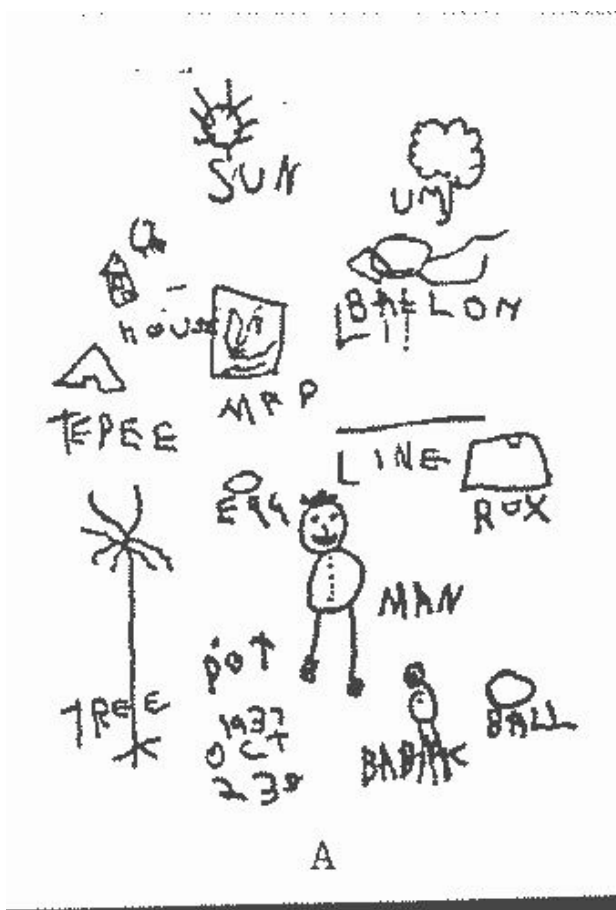
Still a third usage, emphasized by Ernest R. Hilgard (1977), involves the notion of processing information at a level that is not accessible to conscious awareness. Despite these contrary connotations, the sheer longevity of the concept of dissociation suggests that it may be implicated in the hypnotic process. To be a useful concept, however, it needs a reformulation that removes the various ambiguities of current formulations.

Does hypnotic age regression produce historically accurate memories?

Hypnotic age regression involves the hypnotized person's ability to "relive" an earlier period of his/her life. It is to be distinguished from thinking about the past, or remembering it; the age regressed person experiences being a younger age in a subjectively vivid and compelling manner, and this is accompanied, quite often, by what appear to be age appropriate changes

in voice, mannerisms and handwriting. Although the age regressed person's behavior can be very convincing subjectively, that is no guarantee of the historical accuracy of anything that a person recalls about his/her past during age regression.

Orne (1951) reports the case of a German-born experimental subject, regressed to age six, when he spoke no English. Drawings that he had made at that age were compared to ones he made when hypnotically regressed to age six, including two drawings he completed while age regressed after he had seen his actual productions of that age. The drawings reported in this study are reproduced in Figure 2. Although the age regressed drawings were certainly child-like, Karen Machover, a clinical psychologist with expertise in children's drawings described them as "sophisticated oversimplifications;" that is, their child-like quality was appropriate to a chronological age greater than the age to which he had been regressed. There are many other demonstrations of this basic observation that novel information, elicited in hypnotic age regression, cannot be taken at face value; it needs, always to be corroborated by independent means before it can be deemed as factual.



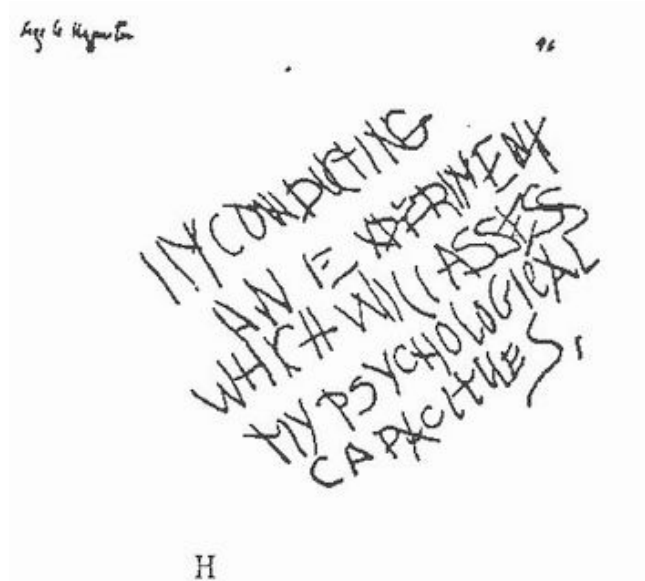
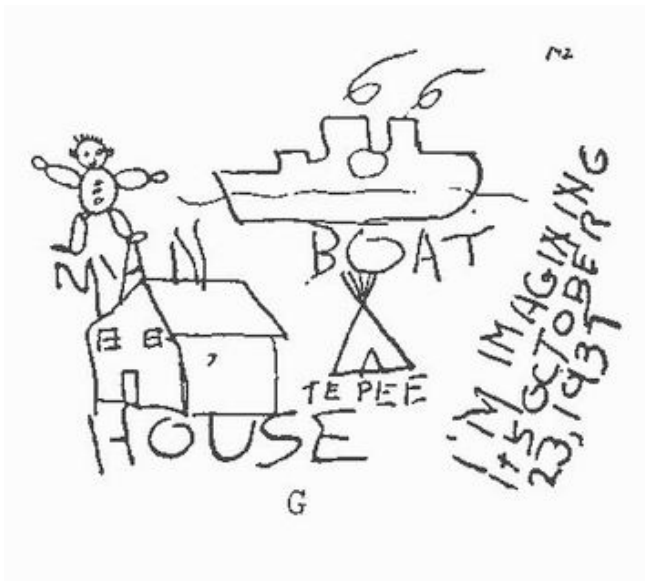
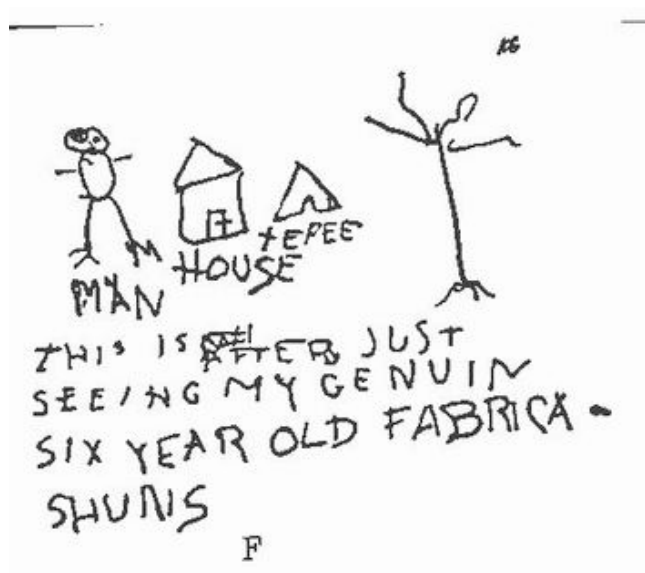
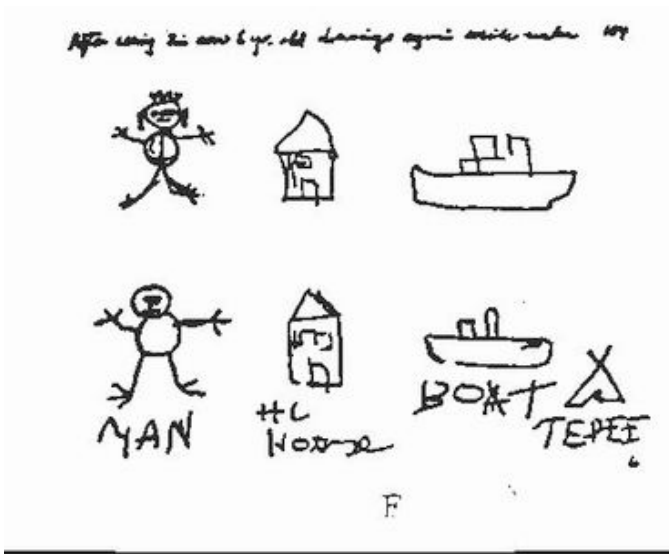
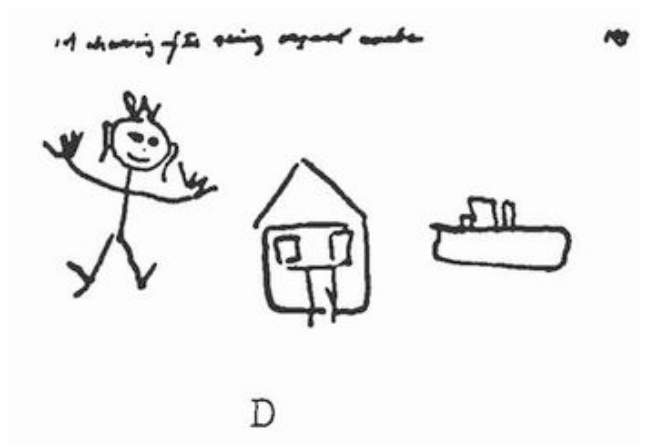


Figure 2. Drawings by an experimental subject at the age of 6 years, age regressed to 6 years, and out of hypnosis while

imagining what he might have drawn at age 6 (from Orne, 1951).

- A. Original drawings at age 6.
- B. Drawings done when age regressed to 6 years.
- C. Drawings done 2 weeks later when age regressed to 6 years a second time.
- D. Drawings done when age regressed to 6 years after seeing the originals prior to hypnosis.
- E. Drawings done while age regressed after awakening and repeated showing of the originals in the awake state.
- F. Drawings done while age regressed to age 6 after the originals were shown during hypnosis.
- G. Drawing done in a waking imagination condition when asked to imagine how he might have drawn at the age of 6 years.
- H. Dictation written while age regressed to 6 years. Note the superficial resemblance to a child's writing.

It has been found, also, that people respond differentially to hypnotic age regression. Approximately 50% of individuals who are able to experience it report duality. When questioned about their subjective experience, they indicate that they felt both adult and child (either simultaneously, or in alternation). The remaining 50% report a quasi-literal regression; they state that they really felt that they were the suggested age, and had no sense of being an adult (Perry & Walsh, 1978). The only hypnotic item with which this differential response to age regression correlates is the "hidden observer" effect (E. R. Hilgard, 1977), which seeks to index dissociation.

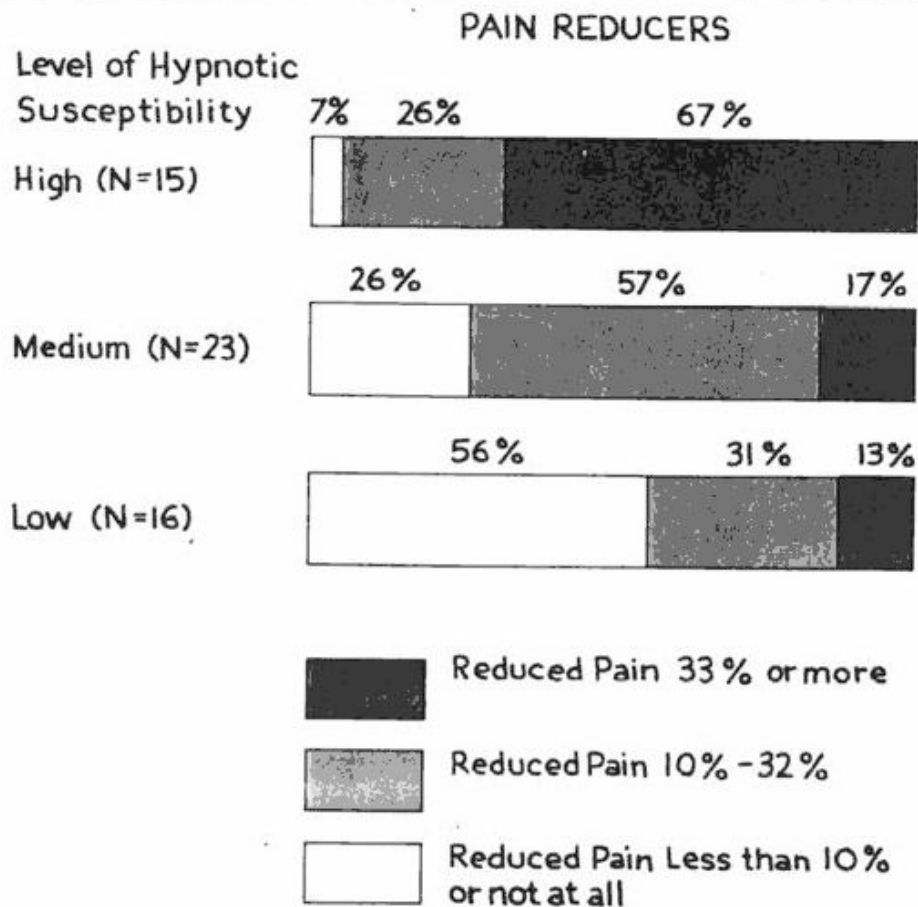
From this, there is a suggestion here that dissociation is, also, a differential phenomenon, at least among those who are able to experience it. Current evidence suggests that it is found, almost exclusively, among high hypnotizables -- that is the top 10-15% of the population. It is possible, however, that with the development of dissociation measures that are less difficult psychometrically, more people of moderate hypnotizability will be found to experience milder forms of dissociation.

(For those interested in further reading on the subject of age regression, the following is suggested: Nash, M. (1987) What, if anything, is regressed about hypnotic age regression? Psychological Bulletin, 102, (1) 42-52.)

What is meant by the metaphor of a "hidden observer"?

The "hidden observer" is a metaphor for dissociation; this latter term was introduced by Pierre Janet (1889) to indicate that ideas could be cut off, or detached from the mainstream of consciousness, where they could then fuel symptoms. Ernest R. Hilgard sought to broaden this concept, developed in the clinic, in an experimental attempt to understand the mechanisms underlying hypnotic analgesia (pain reduction). A probabilistic relationship has been found between hypnotizability and hypnotic analgesia using cold pressor pain (immersing an arm in 0 degrees centigrade iced water for 60-90 seconds).

It has been found that 67% of high hypnotizables report a reduction of pain by one third or more, as opposed to 17% of medium susceptibles, and 13% of low hypnotizables (E. R. Hilgard & Morgan, 1975; see also E. R. Hilgard & J. R. Hilgard, 1975). This finding is diagrammed in FIGURE 3. [The criterion of a reduction of pain by at least one third has been adopted by pain researchers as indicating a significant diminution of pain, in much the manner that statisticians have opted for $p < .05$ as indicating a statistically significant effect.]



Reduction of pain through hypnotically suggested analgesia as related to susceptibility to hypnosis (from E.R. Hilgard & Morgan, 1975).

Hilgard argues that measurable pain that does not register in conscious awareness must register at a covert "hidden" level that is somehow dissociated from the mainstream of consciousness. Hence the metaphor of the "hidden observer," which is designed to point to this state of affairs at a descriptive level.

Despite laboratory attempts to link the "hidden observer" effect to performance on other hypnotic items, it has been related only to the differential response to age regression. Experimental subjects who report experiencing a "hidden observer" report, also, duality in age regression; those who do not report a "hidden observer" experience report a quasi-literal experience of age regression in which they have only a sense of being the age suggested, and no sense of being an adult (Nogrady, McConkey, Laurence & Perry, 1983).

The finding cannot be attributed to the demands of the situation, that is, voluntary compliance with what the hypnotized person perceives as desired by the hypnotist; the demand of the "hidden observer" item is to report this experience while the demand of age regression is to report a quasi-literal regression, with no awareness of being an adult. In other words, an account of this relationship in terms of demand characteristics fails to explain why approximately 50% of high hypnotizables respond to the demands of the "hidden observer" item and not to the demands of an age regression item -- and vice versa.

Among other things, these data suggest that if dissociation is a viable construct, then it is a differential phenomenon; that there is more than one way of experiencing it. Thusfar, however, this observation of a possible differential dissociation response being related to a differential response to age regression has not been integrated into the mainstream of current theorizing about dissociation.

What is the connection between Hypnosis and Multiple Personality Disorder (MPD) [recently renamed as Dissociative

Identity Disorder (DID)]?

Hypnosis is tightly linked with the diagnosis of Multiple Personality Disorder. Colin Ross, one of the leading proponents of MPD, wrote in 1989 that "There is a strong connection between MPD and hypnosis, in etiology, phenomenology, and treatment," (p.64) and "most interventions in MPD may have a hypnotic component." (p. 275) The 1994 guidelines of the International Society for the Study of Dissociation state that "DID experts generally agree" that self-hypnosis plays an important role in the disorder, that patients will frequently enter trance states during treatment and that hypnotic techniques can help patients in crisis. Hypnosis has often been used to bring out the alters of MPD patients.

History and Frequency of MPD/DID

MPD/DID has a long and complex history. The first two reports of MPD were recorded between 1800 and 1820. According to Coons (1986), by 1980 the scientific literature contained slightly more than 200 such cases. In 1980, 900 new cases of MPD/DID were reported (Coons, 1986), a 450% increase over the previous 170 years. Orne, Dinges and Orne (1984) reported more conservative figures. On their tally, there were from 90-165 cases between 1811 and 1970, and 370-450 between 1970 and 1980. This represents a 224-500% increase. Part of the impetus for this large increase was that the third edition of the American Psychiatric Association's 1980 Diagnostic and Statistical Manual (DSM-III) first recognized MPD (as it was then known) as a distinct diagnosable disorder. It can be seen from Orne et al. (1984), though, that even prior to DSM-III's recognition of MPD as a diagnosable condition, its incidence was rising rapidly. In addition to the rising frequency of the MPD diagnosis, the number of alters found in individuals has also risen dramatically.

Following the publication of DSM-III (1980), the burgeoning incidence of reported MPD/DID cases continued throughout the 1980s and well into the 1990s. It created considerable controversy within professional societies of psychiatry and psychology. Some MPD/DID proponents have argued that it has been underdiagnosed in the past (Ross, 1989). Some maintain that MPD/DID is a rare but distinct condition. Still others believe that it is iatrogenic (that is, suggested implicitly by the therapist). Further, the possibility that MPD/DID can be faked, particularly when a criminal defendant faces legal charges, must be considered. These issues require some amplification.

*The belief that MPD/DID is a rare, but diagnosable, condition comes from Corbett Thigpen and Hervey Cleckley (1984), whose book *The three faces of Eve* (Thigpen & Cleckley, 1957) was later the subject of a Hollywood film; it whetted much public and professional interest in MPD/DID. They reported that in the three decades since *Eve*, they had seen some tens of thousands of psychiatric patients, but in their view, only one of these merited a diagnosis of MPD/DID. A similar observation was recently provided by Frances and First (1999), the Chairperson and the Editor of DSM-IV. In 45 collective years of psychiatric practice, they believe they saw only three genuine cases of MPD/DID. They commented "A good rule of thumb is that any condition that has become a favorite with Hollywood, Oprah, and checkout-counter newspapers and magazines stands a great chance of being wildly overdiagnosed." (p. 288) This observation suggests that if such a condition exists, it is rare.*

Merskey (1992) also takes a skeptical position. In reanalyzing a large number of 19th Century diagnoses, he argues cogently for misdiagnosis in most of them. He argues that a number of them appear to fit equally well as manic depressive illness, organic brain disorders, or manufactured by means of hypnosis and asking such questions as: "Is there anybody else there?" or "Do you have a name?" On the other hand, proponents of the MPD/DID diagnosis point out that such leading questions must necessarily be asked, i.e. a clinician's only hope of diagnosing the disorder is to put the question explicitly. Other clinicians, however, such as Paul McHugh argue that a therapist should never talk to alters.

Sutcliffe and Jones (1962) argued for a similar position, concluding that many of the earlier cases were "probably misdiagnosed" (p. 244). They argued that such diagnoses as brain damage, epilepsy, and schizophrenic regression were more likely. At the same time, they observed that "there remain a considerable number of cases which might be classified as 'multiple personality;' (p. 247). When one compares cases that were discussed by both Merskey (1992) and by Sutcliffe and Jones (1962), most of the cases described by the latter as possible instances of MPD/DID are interpreted by Merskey as bipolar disorders or as factitious personalities created by the therapist. This is a point on which both sets of investigators agree in a number of other cases. Although there is a hazard inherent in diagnosing patients that one has not examined, the problem here is that there is little in the way of hard criteria of inclusion and exclusion for MPD/DID, so that alternative explanations of past (and current) diagnoses of this condition may be inevitable.

See Piper (1997) for a thorough discussion of the problems of diagnostic criteria for MPD.

Iatrogenic MPD

Much of the evidence for MPD/DID being iatrogenic (that is, suggested and fashioned by the therapist) is anecdotal and/or circumstantial.

One sort of evidence is that few therapists ever see it. A survey conducted by Modestin (1992) found that only three therapists made 58% of 221 diagnoses of MPD/DID. Although this fact might indicate that the doctors who do find MPD/DID are particularly skilled, it might equally point to the fact that those therapists are prone to creating MPD/DID with their patients. There is also the intriguing observation that compared with North America, the diagnosis of MPD/DID is made rarely in Europe (Aldridge-Morris, 1989), even though it was once a highly popular diagnosis in 19th Century France (Merskey, 1992). Although this might point to social and/or psychological conditions in the United States that are conducive to MPD/DID, it might equally be evidence of the disorder's iatrogenic character in many cases.

*As a case in point, Columbia University psychiatrist Herbert Spiegel (Borch-Jacobsen, 1997) reported on the case of Sybil, one of the high profile MPD/DID cases of the 1980s whose story, like *Eve*, became a best selling book (Schreiber, 1973) and later movie. While Sybil was being treated by Cornelia Wilbur, M.D. and displaying an array of alter personalities, she was also seeing Spiegel. Early in this encounter, she asked Spiegel if he wanted her to be Helen. Helen, she explained, was who Dr. Wilbur wanted her to be in their therapy sessions. Spiegel indicated that it would be acceptable for her to be whomever she chose; she settled for being herself with Spiegel.*

*This report raises a particularly vexatious issue: patients with MPD/DID are customarily represented as having no voluntary control over the emergence of alters. Without doubting that Sybil suffered from difficulties that required psychiatric intervention (a point on which Spiegel and Wilbur agreed), one must ask whether Spiegel's report invalidates Wilbur's MPD/DID diagnosis. Similar issues are raised by a recent autobiographical account of MPD, *First Person Plural* (West, 1999). In a recent review, Piper (1999) pointed out some inconsistencies in West's story such as his enrollment in a university graduate program, despite some reportedly severe memory impairments. Piper also noted that West forbade his alters from emerging when he had sexual relations with his wife; again the issue of voluntary control over the emergence of alter personalities is raised.*

Retractors provide further evidence that MPD/DID can be iatrogenic. Typically, retractors are women who entered therapy and later publicly accused parents of childhood sexual abuse, only to withdraw the allegation after they stopped therapy. Many retractors have described in compelling detail how their therapists interpreted every possible symptom as a consequence of the MPD/DID that developed because they repressed their memories of childhood abuse.

One variation of this more general theme is described by Pasley (1993), who was sexually abused by a stranger at a swimming pool and never forgot it. She reports that: "[a]lthough my therapist was only the second person I had ever told that story to, it was not dealt with in therapy because it wasn't 'deep' enough. It wasn't repressed so it couldn't have caused me problems" (p. 363). Instead, she was diagnosed as having MPD/DID, and spent four years in therapy searching for repressed memories of sexual abuse by her father.

There is good reason to suspect that additional personalities can be elicited iatrogenically by a therapist who believes in the pervasiveness of multiplicity, and who communicates this belief to the patient. Patients want to please their therapists for this reason, and it is often a difficult "call" in any specific case to disentangle the various explanations. In some cases, multiplicity may be fact; in others it may be a lie; in still others it may be confabulated; and in still others it may result from an inappropriate suggestion by a therapist.

Simulation of MPD/DID

Legal cases have presented the opportunity to examine whether people can simulate MPD/DID. There have been reports of criminal defendants presenting a MPD/DID defense as well as research showing that the disorder is easily simulated (Spanos, 1994). The most meticulously documented legal case (Orne, Dinges & Orne, 1984) involved Kenneth Bianchi (a.k.a. the Hillside Strangler) who, with his cousin Angelo Buono, was accused of raping and strangling several young women in the Los Angeles and Bellingham, WA areas over a 14-month period between 1977-78. Although two clinicians diagnosed Bianchi as having MPD/DID, Orne testified successfully in court that he was simulating hypnosis (which had been employed by one of the clinicians to elicit his apparent underlying multiplicity), and also that he could be simulating MPD/DID.

Because there was compelling physical evidence of Bianchi's involvement in these crimes, the question of multiplicity was mainly one of his degree of criminal responsibility; this boiled down to a question of whether there existed a putative alter personality that knew the difference between right and wrong. Although two clinicians in this case argued that Bianchi was a

multiple, the court found Bianchi guilty of first degree murder and rejected the diminished responsibility claim of the MPD/DID defense. Along with the experimental data presented by Spanos (1994), this case suggests that it is easy for a motivated person to simulate MPD/DID and to fool experts in the field. As indicated earlier, exactly the same state of affairs exists for the simulation of hypnosis. Thus great care should be exercised in diagnosing MPD/DID, particularly with a person in a legal context who stands to gain considerably from such a diagnosis.

Orne, Dinges and Orne (1984) have suggested other considerations in evaluating the plausibility of an MPD/DID defense in a legal context. They argue that there should be evidence that the condition existed prior to any interaction with the clinician who furnished an MPD/DID diagnosis. Further, the various persona should be resistant to suggestion by the clinician. For instance, many clinicians have reported ignoring patient attempts to present themselves as multiples; this has had the effect, quite often, of extinguishing the behavior. Bianchi remained steadfast in the face of attempts by two prior clinicians to elicit a third alter personality, yet provided an additional alter after Orne suggested that it was unusual for a person suffering from MPD/DID to have only two such personalities.

Is sexual abuse during childhood a cause of MPD/DID?

Although some have argued that every person who has been sexually abused is marred for life, others have pointed to research that seems to indicate otherwise.

Most of the clinicians who readily diagnose MPD/DID argue that this condition is a direct consequence of sexual abuse during childhood. This may well turn out to be true, but a recent review of the literature by Frankel (1993) demonstrates that most of the studies asserting this claim make little, if any, attempt to corroborate independently that the reported abuse actually happened. Since hypnosis was used to elicit memories of the abuse, it is always a possibility that these memories were confabulated by the patient, and/or were the result of inappropriate suggestions made by therapists.

Two other concerns about the relationship between childhood abuse and the ubiquity of life-long problems are that studies have failed to separate sexual abuse from general family dysfunction and that very young children do not have the categorical framework by which to identify an incident as abusive (Levitt & Marie Pinnell, 1995). In addition, self-reports about past abuse differ greatly. Not all people report life-long negative effects (Rind, Tromovitch & Bauserman, 1998). Thus, for the present, all that can be said is that no link between childhood sexual abuse and this disorder has been established empirically.

What is the role of hypnosis in the creation of false memories?

In 1985, the Council on Scientific Affairs of the American Medical Association published a statement warning that "recollections obtained during hypnosis can involve confabulations and pseudomemories and not only fail to be more accurate, but actually appear to be less reliable than nonhypnotic recall." The fact that hypnosis might be involved in the formation of false memories was well-known before the false-memory phenomenon became a problem.

Hypnosis does not operate in a vacuum.

Hypnosis has been conceptualized as "imaginative involvement" (J. Hilgard, 1970/79), "believed-in imaginings" (Sarbin & Coe, 1974), and "delusion" (Sutcliff, 1961). As such, the role of hypnosis in creating false memories is likely one of facilitating and even hastening a process whereby a suggested fantasy of the past comes to be accepted as a "true memory." In other sections of this paper we explain elements of the hypnosis process that may be involved in facilitating belief in a false memory: Hypnotic susceptibility, Role of imagination, How hypnosis affects memory, Hypnotic hypermnnesia, Confusion about dissociation and Age regression.

To appreciate fully the role of hypnosis in the creation of false memories, it is important to remember that false memories of childhood sexual abuse can develop without recourse to hypnosis. Although hypnosis might re-awaken childhood fantasies, it is in the context of the beliefs and actions of the hypnotist, an authority figure, that the fantasy might come to be interpreted as historically accurate. We look at the context, the beliefs and processes, in which hypnosis may facilitate false memories.

Causal Connection: Experience in the various countries where false memories of childhood sexual abuse have surfaced in relatively large numbers in recent years reveals a consistent pattern of memory creation. What happens, typically, is that a demoralized adult (Frank & Frank, 1991) comes to believe that s/he cannot negotiate life's current difficulties alone and seeks

out a therapist. The person is unfortunate enough to choose a therapist who believes that all psychological distemper, from *abulia* (chronic procrastination) to *zoophilia* (sexual attraction to animals), is the product of repressed memories of sexual abuse during childhood.

Necessity of Memory Recovery: In addition to clinging to the over-simplified belief that all dysfunctions are causally linked to repressed incest memories, such therapists also believe that "recovering" abuse memories will provide the person with insight into his/her difficulties, and that this will lead to a dissipation of symptoms. (While it is true that knowing why one behaves in a maladaptive manner can be beneficial, there is no evidence that such insight necessarily leads to symptom reduction.) A therapist highly committed to this assumption takes a patient's disavowal of abuse as evidence of being "in denial." This diagnosis may be made without taking a full case history; it places the novice patient in a subtle bind. There is something wrong with the patient if he or she remembers -- that is, the patient has been abused. But there is also something wrong if he or she does not remember -- that is, the patient is in denial. Unless the patient decides to terminate therapy, he or she is embarking upon a long and gruelling odyssey in search of repressed memories of past events that may not have happened.

Books or Experts Reinforce Belief: In this type of therapy, sometimes referred to as *Recovered Memory Therapy (RMT)*, the therapist typically provides the patient with bibliotherapy. Often s/he is referred to the book best known for its commitment to a belief in the ubiquity of repressed incest memories: *The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse* by Ellen Bass and Laura Davis. (Bass and Davis are open about the fact that they have no professional training and have a lesbian perspective. (Bass & Davis, 1988, p. 14, 76-77)) The suggestive power of this book has been shown in the uncanny resemblance of many accusations to the book's script for "recovering" repressed memories

Mistaken Beliefs about Memory: In some cases, the diagnosis of *MPD/DID* may be made based upon the belief that people with multiple personality were sexually abused during childhood even though as adults they do not remember. Given that "remembering" plays such a critical role, hypnosis may be recommended for recovering lost memories. The therapist and patient likely hold the mistaken beliefs that hypnosis is highly effective in restoring "true memory" and that there is no need for independent corroboration for the reports that emerge with hypnosis. Of course, the problem is that hypnotically enhanced recall, while confidently believed, may be highly confabulated.

Mistaken Belief that Repressed Memories are Different: Another unsubstantiated belief is that repressed memories do not follow the general laws by which "everyday" memory is processed at the acquisition, retention and retrieval stages. It is suggested that at the acquisition stage the memory is encoded with photographic precision. It is further believed that at the retention stage the memory is encapsulated and is not subject to modification by such factors as post event information, or by self-serving reappraisals of the traumatic event(s). Finally, at the retrieval stage, it is assumed that the memory is not in any way modified by such factors as highly suggestive memory recovery techniques, such as leading questions ("Do you remember that your mother was too overwhelmed by the traumatic events to offer you assistance?"). The scientific research is clear that there is not the slightest scientific evidence for the existence of such an acquisition/retention/retrieval process. (see Kihlstrom, 1994; Loftus, 1979 for accounts of how memory is acquired, stored and retrieved).

Cult-like Behavior: Following the diagnosis of repressed incest memories, with or without an *MPD/DID* diagnosis, a number of procedures may be employed that reinforce the belief that the diagnosis is correct. Clients are sometimes urged to stage an angry confrontation with the alleged abuser(s), not permitting him and/or her to refute the accusations. They may be advised to "get strong by suing" at the same time as being informed that "you are not responsible for proving that you were abused" (Bass & Davis, p. 137). (This may well be the worst legal advice of the millennium.) Further, they are usually advised to break off all relations with the family and with anybody else who questions the abuse narrative.

In effect, this places the patient in a cult-like environment, since by following these instructions the patient is almost certain to be surrounded exclusively by like-thinking others and will not be exposed to a demurring voice. This effect may be magnified if the person follows another piece of advice -- to become involved in an incest survivors' group. For people who have yet to "recover" a memory of sexual abuse during childhood, this can increase the pressure to conform to group mores and to "remember" something that justifies their presence in such company.

This process has been documented by Nelson and Simpson (1994) in a study of 20 retractors. Of 14 respondents who developed visualizations of childhood sexual abuse during the course of group therapy, all but one reported that similar or identical memories were shared by other group members. Typical comments were: "We had very similar alters (*MPD* alter personalities) and memories. One woman would feel left out because she didn't have a particular alter everyone else had, and she wanted it" and "If you don't have a memory you feel like you have to come up with one to compete with everyone" (p. 126).

Suggestive Techniques: Another suggestion that may be given to the patient who has no abuse memories is to question the belief that her childhood was a happy time. The client is admonished to grieve for the happy childhood that did not actually occur, even though she may think that it did. In some books, hatred is advocated as a healing method, and fantasies of murder and castration of the alleged abuser are encouraged -- contrary to all reputable clinical belief and practice.

Writing exercises are frequently suggested to help recover memories. It is not unusual for a person to be urged to write non-stop, without regard for syntax and punctuation, on such topics as how the putative abuse occurred, and of factors in the father's childhood that may have predisposed him to the alleged pedophilia. In the accommodating environment of an approving therapist or a survivors' group, such a hastily written account of intimate details of a father's fantasized past may eventually become highly plausible and believable to the patient. Research by Elizabeth Loftus has demonstrated how the process of imagining an event inflates the likelihood of a person coming to believe it. (Loftus & Mazzoni, 1998)

After all of this, failure to "recover" the sought-after abuse memory is brushed aside with such assurances as: "If you are unable to remember any specific instances... but still have the feeling that something abusive happened to you, it probably did" (Bass & Davis, 1988, p. 21). And: "If you think you were abused and your life shows the symptoms, then you were" (ibid, p. 22). Further: "If you don't remember your abuse you are not alone. Many women don't have memories and some never get memories. This doesn't mean they weren't abused" (ibid, p. 81).

In brief, some of the possible influences that may lead to false memories include a treatment based upon the theory of repression, the use of such procedures as hypnosis, guided imagery, dream interpretation, and sodium amytal represented as "truth serum," and the therapist urging the patient to cut off all contact with an accused parent who denies being an abuser. In addition, treatments that focus upon regression to infantile experiences, the emergence of multiple personality, the recollection of past lives and the experience of alien abduction are all at high risk to produce spurious autobiographical memories. The risk is increased when these techniques are used in a culture that frequently depicts the recovered memory stories in movies, books and TV.

A demoralized person may be particularly vulnerable to a subtly woven script that sees all human distempers as a consequence of repressed memories of childhood sexual abuse. It is conceivable that a person may develop such a scripted abuse memory without recourse to a hypnotic procedure. But from what we know about hypnosis, it is highly probable that a person exposed to some hypnotic technique will more readily and more confidently come to believe in that for which there is no evidence.

What is the difference between formal and "disguised" hypnosis?

Formal hypnosis is straightforward; one person (the hypnotist) informs another person (the experimental subject, the clinical patient, or the crime witness) that s/he, with the person's permission, will attempt to induce hypnosis.

"Disguised" hypnosis, by contrast, is an imagination-based procedure that the practitioner does not represent as hypnotic in nature. Nevertheless, it taps into the mechanisms thought to underlie responsiveness to hypnosis -- namely imagination and absorption (Perry, 1995). Here, it needs to be emphasized that a large variety of procedures can be represented as hypnosis; Estabrooks (1948) reported successful induction of hypnosis in one member of a group of patients in therapy by representing a gramophone recording of a Swiss yodeler as hypnosis.

Earlier formulations of "disguised" hypnosis stem from the clinical work of Milton Erickson during the 1950s and experimental research of Theodore X. Barber during the 1960s. A renewed interest in disguised hypnosis has developed in recent years as the result of it being adopted by many therapists who search for repressed memories of childhood sexual abuse. In practice, procedures such as guided imagery, regression work, dream analysis, "relaxation" and sodium amytal represented as "truth serum" function as hypnosis by another name.

Can hypnosis be dangerous?

Hypnosis is not a dangerous procedure in itself, but complications may occur as the result of faulty technique on the part of the hypnotist, or from misperceptions on the part of the hypnotized person. The topic is a vast one (see Laurence & Perry, 1988, p. 397-318 for a review). In terms of technical errors by the hypnotist, there is the occasional report of a hypnotized person failing to emerge from a trance. There are various ways of resolving this difficulty, but in a safe environment, the worst that can happen is that the hypnotized person finishes up having a prolonged sleep.

Sometimes, hypnotic age regression may elicit traumatic memories of past events (which may or may not have happened); again, there exist straightforward procedures for relieving the painful emotion of such memories, regardless of whether they are based upon fact or fantasy. Further, there are data that show that the failure to cancel or remove a suggestion after it has been administered and tested in trance may lead to its post-hypnotic persistence. The simple remedy for this problem is for the hypnotist to be meticulous in canceling suggestions (unless the suggestion is a therapeutic one designed to persist into the post-hypnosis period; for instance, that following hypnosis, the patient will feel better and will function better).

A further area where care is required is in treating clinical pain with hypnosis. Before embarking upon such a treatment, it is important that the patient undergoes a neurological examination to ensure that the pain is not the product of an undiagnosed, organic origin. For example, there are a few cases in which a patient's headaches were treated by hypnosis before it was recognized that it resulted from an unsuspected brain tumor. Although hypnosis was effective in masking the pain in these cases, the appropriate treatment was surgery. Of course, once the correct diagnosis has been made in such cases, hypnosis might well be an appropriate means of reducing the pain during the waiting period for the scheduled operation.

On the other hand, many of the complications that can occur with hypnosis stem from the hypnotized person's perceptions of it. Most of them can be avoided by questioning the person carefully during the pre-hypnosis period about his/her knowledge and beliefs about hypnosis. Beliefs such as that the hypnotized person is an automaton, unable to resist any suggestion that is administered, or that the person may not be able to terminate trance, can best be met with factual knowledge, or even the invitation to resist a particular item during hypnosis.

Again, the belief that post-hypnotic amnesia is permanent (to the extent that the person is unable to remember any of the events of hypnosis) can be defused by explaining that amnesia is reversible, and that when the amnesia suggestion is administered, a post hypnotic cue ("now you can remember everything") will be given so as to relieve the amnesia. On some occasions, also, when an affect-laden memory is elicited, the operator may place the onus upon the hypnotized person to decide how much, if any, of the traumatic material s/he wishes to recall. For a more detailed treatment of these issues, see J. R. Hilgard, (1974).

It should be emphasized that this section is a distillation of cases of misused hypnosis reported over more than 200 years. Even allowing for the likelihood that such misuses are under-reported, one is left with the impression that, overall, most practitioners of hypnosis during this lengthy time span have been ethical and competent in their utilization of it. By contrast, with the widespread belief in the necessity for excavating memories of childhood sexual abuse, there has been a spectacular increase in the use of dangerous practices in which hypnosis plays a central role. A detailed case report (Macdonald, 1999) may help to crystallize how a procedure that is safe in competent hands can become one that is harmful to patients.

Gail Macdonald's story:

Gail Macdonald is a retractor. She has written an important book about her experiences of incompetent therapy with a hypnosis base. Critics of FMS usually dismiss retractors in a patronizing manner, arguing that if they were mistaken the first time when they made the accusation, how can they be believed when they decide that it was false and retracted it. Ms. Macdonald is not so easily dismissed. Her therapist had encouraged journaling, and by the end of her treatment, she had 20 exercise books (each of approximately 100 pages) in which her most intimate thoughts about what was happening during therapy were recorded. In addition, she was able to obtain a copy of her therapist's notes; these provided external validation of her subjective reports of the treatment. It may be of additional relevance that she was the first patient in Canadian legal history to win an out-of-court settlement against a community mental health clinic, one whose magnitude she agreed not to disclose, beyond saying that "all parties were satisfied" (p. 83).

At the time she entered therapy in the Fall of 1989, Ms. Macdonald lived in a moderately sized town in Ontario, Canada. Her master's level therapist was a Californian designated Joe in the book. He was employed by the community mental health clinic, and, as she later discovered, was not permitted to diagnose patients because of his lack of experience and training. Her presenting problem involved overindulgence in alcohol, drugs (to a lesser extent), and diffuse anger towards her father (an alcoholic).

*Very early in her treatment, Joe hinted that she had been sexually abused during her childhood. This "diagnosis" was based upon no more than his belief that her alcohol addiction, her low level of self-esteem, and her unhappiness were the products of repressed sexual abuse memories. He was undeterred by her reporting that she had no memory of any sexual abuse, countering that it is common for people in her situation to be in denial. He prescribed *The Courage to Heal* and a book by Laura Davis entitled *Handbook for Sex Abuse Survivors* as bibliotherapy; she purchased both books and read them.*

From a very early time in the treatment, a strong transference appears to have developed between therapist and patient that had overtones of love. Over and above formal therapy sessions, there were walks by the bay and exchanges of confidences; Joe told her that it was difficult for him to confide in others because of his professional life, and that because of time constraints, he was unable to form a long-term personal relationship. He also admitted to loneliness.

During this first year of treatment, Gail remarried -- to another recovering addict. This new husband relapsed often; this, she said, brought her closer to Joe. She began to have dreams about him, and although she reports feeling embarrassed, she wrote them in her journal so that he would, inevitably, see them. His reaction to this was to say that it is normal to be attracted to one's therapist, but there would be no problem with this for as long as they discussed these feelings. Within a year, Gail was seeing Joe on a regular weekly basis for formal treatment sessions, interspersed with walks and coffee. This served to blur the professional lines between treatment and a personal involvement, since it may have placed Gail in the position of treating Joe for his loneliness -- and without financial compensation.

Over the next year, there were some major developments in the manner that the treatment devolved. Joe introduced the notion of an inner child, explaining that because of Gail's alcoholism, a "part" of her was wounded, and it needed assistance to develop emotional maturity so that she could learn to cope more effectively with difficulties. At around this time, he also introduced the technique of guided imagery, in which she was to imagine a safe spot to which she could retreat and explore her feelings, undisturbed by more mundane concerns. He explained that for some people an imagined armchair by the fireplace or a nature scene such as a seashore could be a safe spot. They decided that Gail's safe spot would be a meadow surrounded by trees with a brook flowing through it.

It needs to be understood that techniques such as guided imagery, and the metaphors of an inner child and a safe spot, are well recognized in the clinical literature of psychology, and in themselves, are not inherently harmful. Indeed, they can be beneficial to patients when deployed skillfully. But they can equally have unintended adverse effects, since all of them involve a direct appeal to the patient's ability to fantasize. If the stated purpose of the therapy is to resurrect buried memories of sexual abuse during childhood, this appeal to fantasy and imagination always risks a false memory. The problem is compounded when an elicited memory confirms the therapist's suspicions, and the patient takes it at face value with no corroboration.

The same can be said for dream analysis. Joe encouraged Gail to keep a journal of her dreams. He expressed great pleasure at the result, telling Gail that a breakthrough was imminent and that her denial was lifting, since the truth was beginning to emerge. No doubt this was highly encouraging to her until one day, without warning, he asked whether she remembered her father abusing her sexually. Not unreasonably, she was mortified that her dreams could contain memories of her father abusing her sexually. Even worse, from her point of view, was that if this interpretation of her dreams was correct, it meant that she had forgotten the abuse -- it raised the questions of how she could have participated in incest (however unwillingly) and of how she could not have remembered it.

Joe explained that when children are abused sexually, they "split off," relegating such memories to their subconscious until a later time when they feel strong and secure enough to acknowledge them. In the face of this apparent revelation, Gail left the office feeling "shattered and scared." Nevertheless, that night, following Joe's suggestion, she looked through old family photos, seeking to find even the slightest trace of evidence that such an abuse had occurred. She cried all night at the thoughts of her father having betrayed her trust, and of her being so "messed up" as to not remember it.

She phoned Joe the next day for an urgent appointment, telling him that she felt she was "coming apart at the seams." Clearly, Gail was becoming highly fragile and vulnerable; not heeding some obvious warning signals, Joe suggested she go to her safe spot using the guided imagery procedures. This time, she said that it felt different, that she was not alone. Joe suggested that she look around to see if anyone else was present.

It transpired that there were seven young people in the safe spot. This was interpreted by Joe as evidence of MPD; the young people she had fantasized with considerable clarity were interpreted by him as alter personalities, each harboring memories that she could not bear to remember. An intensification of symptoms followed; she began to hear voices, and this was accompanied by severe headaches. Joe interpreted the voices as belonging to alters and the headaches as stemming from blocks in the unconscious.

What followed for the next few years has a truly nightmarish quality. She began to sleep an average of three hours a night, and with the combined pressures of sleeplessness and of looking after two young children, she soon lost her a job with a cleaning firm that she had started up with some other women. She became too unreliable to maintain a regular clientele.

Joe advised her to join a support group of women with MPD. Soon she was experiencing time losses, during which she would self-mutilate without realizing what she was doing during these periods of lapsed consciousness. It was not long before every other member of the support group was self-mutilating on a regular basis. As well, Joe convinced her that she had been satanically ritually abused by the priests and nuns of a Catholic school she had attended during childhood.

It was a wretched period of her life, attending the support group, reliving what appeared to be memories of incest and sexual abuse, and listening to reports of similar memories from its other members. She felt desperately lonely, and, by her own description, she had become physically run down. She lost 30 pounds and had dark circles under her eyes from lack of sleep.

Fortunately, a male friend, Dan, had become concerned with this deterioration in her physical health, and suggested to Gail that she seek a second opinion on what ailed her. It led her to take a "temporary" break from therapy, remarkably with Joe's blessing. Within weeks, the voices began to diminish, though they did not disappear completely. Her appetite improved, and she began to sleep full nights. Most important, she ceased her self-mutilations.

These are but the bare bones of a cautionary tale. Gail's road back to full restoration of health and sanity still proved to be a long one, but was much aided by some sound psychiatric intervention. Further, Gail's experiences are not isolated instances of a destructive form of therapy. There have been a number of American legal cases in which an almost identical pattern of therapeutic mismanagement has been documented.

FMSF Legal Survey -- Retractors

Indeed, a recent survey of 112 cases of misdiagnosed MPD/DID (FMSF Staff, 1999) indicated that Gail Macdonald's therapy experience follows an almost predictable path. Of the 112 misdiagnosed cases, 84 individuals (75%) had sued their therapist for malpractice (and, in some cases, fraud). Analysis indicated that, like Gail, most of these people had no psychiatric history prior to entering a therapy in which they were diagnosed as having MPD/DID. Most had opted for therapy as the result of such conditions as postpartum depression or marital difficulties, and had been told that their reaction to these problems indicated a deeper, more serious, dysfunction.

Eventually, they were told that MPD/DID is almost always associated with sexual abuse during childhood, and that repressed memories of childhood trauma is a sign of MPD/DID. This is a commonly held belief in clinical circles, even though there is little evidence in support of it. Indeed, Spanos (1995) reported that childhood sexual abuse was rarely a feature of MPD/DID cases reported prior to 1970; by contrast, cases reported after 1975 have almost always involved descriptions of sexual abuse during childhood. Further, these descriptions became progressively more lurid and extensive.

*Further, hypnosis or its "disguised" variant were employed in approximately two thirds of these cases. As well, these patients were often prescribed strong medications, particularly benzodiazepines such as Valium, Halcion and Xanax. (It should be noted that since he was not medically trained, Joe was unable to prescribe drugs. This did not deter him from urging her to buy equivalent over-the-counter drugs that are more benign in their effects. This was one piece of advice that she did not take.) In addition, most of the subset of patients who sued were told to read such books as *The Courage to Heal*, and *Sybil*.*

*The treatments (if that is what they were) ranged in duration from three to seven years, and the records indicated that, like Gail, the patients showed a steady pattern of deterioration. More than 40% of them (36/84) indicated that they had attempted suicide, or had attempted self-mutilation in response to the horrific images of sexual abuse that emerged. In some cases, the suicide attempts were successful (see *Miller V. Malone, Vance and Charter Grapevine* (1999) in which legal action was taken against two therapists and a hospital by the husband of a woman who killed herself after becoming convinced that she had been a victim of sexual and satanic ritual abuse during childhood).*

As a result of this MPD/DID diagnosis, some were hospitalized in psychiatric wards for up to periods of two years; others were encouraged to hospitalize their young children. They were told that the children were at risk from a ritualistic cult or that the children might show signs of developing MPD/DID.

Conclusion

Overall, there is strong evidence that hypnosis can be dangerous in certain circumstances: When a therapist is minimally trained in clinical procedures, and untrained in hypnosis, and has uncritically accepted the belief that the cause of all psychic dysfunctions can be reduced to a single factor (in this case, repressed memories of sexual abuse during childhood), the potential for faulty treatment becomes a reality. In such a situation, it is likely that a patient, whose morale is fragile enough already, will feel both extreme guilt and extreme self-loathing for having participated in taboo behavior (even though in many

cases of actual child sexual abuse, the child cannot be held morally or legally responsible).

>From the patient's point of view, the additional inability to remember such an event can only add to the feelings of guilt, shame and self-loathing. This is a bad enough situation. When this is linked with unsubstantiated beliefs about MPD/DID, in which hitherto unknown alter personalities guard abhorrent memories of which the patient knows nothing, and by alters that can come and go without his/her conscious volition, the normal human wish to control one's actions is brutally compromised.

Hypnosis, with its appeal to the imagination and its indexing of involition, can intensify and hasten such a process. But much of what transpires when hypnosis is abused in this manner is a matter of how hypnosis is misrepresented to a trusting patient. By the same token, the most widely abused pharmacological substance is Aspirin, but it would be a gross error to conclude that Aspirin is dangerous. It can be, though, when it is employed with reckless disregard.

This is not to wrap the issue of the potential dangers of hypnosis in a shroud of reductio ad absurdum, but rather to point out that there are many procedures and products that can have highly beneficial effects but can still be abused. With hypnosis, the main problem is that a large segment of the public may not be able to distinguish between an ethical, competent and skilled professional and an individual lacking the requisite training -- until it is (as in Gail's case) almost too late.

Can a hypnotized person be coerced into unconsenting acts?

The belief that a hypnotized person can be coerced into doing things s/he would not normally do has had currency within the field of hypnosis since the time of Mesmer. Usually it is couched in terms of whether hypnosis is a royal road to sexual seduction. While there are many cases of unsuccessful attempts to sexually seduce, there exist, also, cases of successful seduction by hypnosis, and they need to be evaluated carefully. In most cases, the main ingredient of these cases is a manipulative hypnotist (usually a man) who convinces a hypnotized person (usually a woman) that she is unable to resist unwanted sexual suggestions.

This is done by capitalizing upon the experience of involition, which, as indicated earlier, is a highly reliable index that a person is experiencing hypnosis. The experience of involition is based upon the abilities of imagination and absorption (and perhaps, dissociation) that the hypnotized person possesses; if she is unaware of this, it can become a simple matter to convince her that this experience of involuntariness is proof that she is in the power of the hypnotist and cannot resist no matter how hard she tries.

This can still be thought of as a danger of hypnosis, but the danger is of a male hypnotist who abuses a relationship of trust by misrepresenting the nature of the hypnotic relationship. He is able to convince a woman that the feeling of involuntary responding really stems from his powers -- rather than from her ability to become imaginatively involved. A part of this danger comes from a lack of public education on such questions, despite substantial attempts by professional hypnosis societies to provide accurate information about hypnosis and its alleged coercive power.

It may be a matter of definition whether the activities of therapists utilizing hypnosis that result in false memories of childhood sexual abuse constitute a form of coercion. The main ingredient of the FMS situation is the implanting of an erroneous memory, based upon a faulty theory of the cause of human psychic dysfunction. No coercion occurs in the sense of modifying the hypnotized person's perception of the cause of his/her experience of involition. It could be argued, though, that such injunctions as to stage an angry confrontation with the putative abuser and breaking off all ties with the family are highly coercive instructions.

Where this analysis breaks down, however, is with the observation that many RMTs obtain identical effects without recourse to hypnosis. While the imaginative involvement of hypnosis may facilitate the process by which people come to believe that a scripted memory of sexual abuse during childhood is "true memory," this process appears to be more a function of vulnerable patients trusting a therapist to the extent of believing what they are told during the course of treatment. As was indicated earlier, there is a difference between suggestions made in therapy and hypnotic suggestions. For this reason, it appears that the method of performing therapy, rather than a utilization of hypnosis as a part of that therapy, is the primary ingredient in the establishment of a false belief that a person was sexually abused during childhood.

How is hypnosis used in entertainment, therapeutic, and forensic contexts?

Whenever the behavior of a hypnotized person is being evaluated, it is important that the context in which it occurs be examined. One can arrive at quite radically different conclusions about the nature of hypnosis, depending upon whether it has been dispensed on the stage for entertainment purposes, in the clinic for therapeutic reasons, or in the forensic context in an attempt to bolster the fragmented memory of a crime victim or witness who may have been traumatized by such an experience.

Stage hypnosis

Stage hypnosis is the foremost source of the stereotypes that abound about hypnosis. The belief that the hypnotized person is an automation, completely under the sway of the hypnotist is the most pervasive of all folkloric misconceptions about its phenomena. In actuality, candidates for stage hypnosis are screened by the stage hypnotist for a high level of hypnotizability. Once this is established, the next step is to determine that the volunteer endorses the "rules of the game" of stage hypnosis, which is to entertain an audience.

It is implicit in this "contract" that the stage volunteer has a mandate to behave in a manner that might, ordinarily, be embarrassing and/or transgressive of normal social conventions. Indeed, hypnotized individuals will be returned, rapidly, to the audience if they are undemonstrative and do not engage in the antics suggested by the stage hypnotist. In other words, the stage context provides a license to "act out" a variety of ordinarily proscribed behaviors in public, without fear of reprisal. In such a situation, what appears to be a demonstration of power exercised by one person over another is, in reality, a willingness on the part of the hypnotized person on stage to abide by the license to entertain an audience by acting silly.

Therapeutic hypnosis

Therapeutic hypnosis involves the grafting of hypnotic procedure onto any of the dozens of recognized psychotherapeutic techniques. Hypnosis has been utilized successfully as an adjunct, or ancillary, procedure in therapy that is psychoanalytic, gestalt, non-directive, or any of the many varieties of behavior modification that are based upon learning theory. In this sense, there is no such thing as hypnotherapy; only a number of traditional approaches to psychotherapy that amalgamate hypnosis successfully as a part of the treatment "package." Whereas stage hypnosis is, primarily, for entertainment, therapeutic hypnosis is directed towards helping a person placed in the role of patient to alter his/her behavior by replacing self-defeating habits and patterns with adaptive ones. Therapy focused on excavating "lost" memories of childhood abuse, by contrast, is not therapeutic since it seeks to treat psychic distresses by resort to a theory of repressed incest memories and a belief that such "insight" leads to the automatic dissipation of symptoms. There is no evidence to support these beliefs.

Forensic hypnosis

Forensic hypnosis is predicated upon some questionable assumptions discussed earlier, particularly the belief that memory is reproductive rather than reconstructive, and that there is a hypnotic hypermnnesia effect. It is true that seemingly inaccessible memories may emerge in a hypnotic context (Nash, 1994; Raginsky, 1969), but there is never any certainty that when this occurs in hypnosis, it is caused by hypnosis. In addition, as emphasized earlier, hypnotically elicited recollections are not necessarily true, no matter how vivid and subjectively compelling they may be to the hypnotized person or to an observer of his/her behavior.

In recognition of this, 25 American State Supreme Courts out of 30 that have heard cases that had a hypnosis component have placed per se (that is, automatic) exclusions on hypnotically elicited testimony (State v. McClure, 1993). As opposed to hypnosis as a form of entertainment or as an adjunctive technique for modifying behavior, the main characteristic of forensic hypnosis is that it seeks to elicit additional memories (which may or may not be accurate) of a crime event.

All of these differ from experimental, laboratory hypnosis. What is unique about the laboratory context is that the hypnotized person agrees to assist an investigator to learn something additional about hypnosis and (hopefully) to contribute to a scientific understanding of it (Orne, 1959). This, despite token payment at best, and the likelihood of experiencing pain, boredom and fatigue over a prolonged period. This more altruistic role for the hypnotized person is in marked contrast to entertaining an audience, having one's behavior altered by clinical procedures, and "restoring" memories of a crime in a forensic setting.

What are some of the clinical successes and failures with hypnosis?

A review of clinical outcome studies of treatments that utilized hypnosis (Wadden & Anderton, 1982) found that it is most effective in the treatment of clinical pain, asthma and a variety of dermatological conditions (such as warts and hives), and less effective in the treatment of smoking, alcohol excess and weight loss. Many investigators have recognized a psychological component to the conditions for which hypnosis is most effective, but at the very least, all can be viewed as complaints that were not initiated by the person who comes to suffer from them. By contrast, smoking, alcohol excess and many problems of

overweightness can be seen as self-initiated behaviors. Precisely why hypnosis can be highly effective with one set of problems and relatively benign in its effects with another is not at all well understood.

There are, however, some intriguing data on questions that need to be researched more extensively. One such finding is that pain reduction bears a probabilistic relationship to hypnotic susceptibility -- the more hypnotically responsive a person, the better the betting odds that s/he will obtain substantial pain relief from hypnosis. This has been found in both experimental (Hilgard & Morgan, 1975) and clinical settings; in the clinic, hypnotizability has been a major factor in the successful treatment of headache and vertigo in skull-injured patients (Cedercreutz, Lahteenmake & Toulkoura, 1976), and in the treatment of migraine (Cedercreutz, 1978). Hypnotizability may be linked, also, to the successful reduction of the frequency and intensity of asthma attacks (Collison, 1978).

Further, being highly hypnotizable may predispose a person to phobia. In a review of eight studies that investigated this relationship, Gerschman and Burrows (1994) found confirmation of this hypothesized relationship in six of them. The predisposition of high hypnotizables to phobia meshes well with conceptualizations of hypnosis as imaginative involvement, "believed-in imaginings" and delusion; phobia represents a striking instance of fantasy that is highly involving to the point of believability.

By contrast, no relationship has been found for hypnotizability and successful treatment of cigarette smoking (Perry, Gelfand & Marcovitch, 1979). Rather, the main factor that appears to be linked to success with smoking is the client's motivation to quit the habit; many people present themselves for smoking treatment under the mistaken belief that hypnosis is so powerful a procedure that they will not have to make any individual effort themselves. Recognizing this, many current clinicians of hypnosis will not treat smokers until they demonstrate that they are motivated strongly to quit. The same can be said of alcohol excess and weight loss; outcome is unrelated to hypnotizability and more strongly related to client motivation.

Although the Wadden and Anderton (1982) study indicates the conditions with which hypnosis is most and least effective, it must be remembered that their conclusions are based upon a meager collection of outcome studies. A thorough clinical text (Crasilneck & Hall, 1985) indicates that hypnosis has been attempted across the broad gamut of psychological and medical afflictions and with an unspecified degree of success with most of them. These successes, though, are documented by case history reports, usually involving the treatment of a single patient. Hence, there is no way of knowing how effective, or ineffective, hypnosis is with most of the difficulties to which it can be applied.

All that can be said, at present, is that sometimes hypnosis is effective and sometimes not and that it is difficult to predict who will benefit from it. Interestingly, Sigmund Freud (1891/1970) came to the same conclusion as a result of his brief experience with clinical hypnosis; he noted that failures occurred with patients in "deep" hypnosis and successes with patients who were "lightly" hypnotized (where "deep" and "light" hypnosis are rough clinical equivalents to high and low hypnotizability). It remains a major research challenge to flesh out the finer details of how effective hypnosis is clinically with a variety of presenting problems, and for whom.

What are some current controversies in hypnosis?

Many of the issues already discussed concerning the effects of hypnosis upon memory are controversial. There are those who believe that there is a hypnotic hypermnesia effect, or that confidence is not enhanced by hypnosis (see, Brown, Schefflin & Hammond, 1998). A current major controversy concerns traumatic memory. Some argue that such memories are processed by the brain in a manner different from untraumatic memories; whereas everyday working memory is processed at the level of the hippocampus and its connecting areas, traumatic memories are thought to be processed by the limbic system, and stored, probably, at the level of the amygdala (Brown et al., 1998; Kristiansen, Felton & Hovstad, 1996). This may turn out to be true; currently there is insufficient evidence bearing on this limbic involvement for traumatic memories (Shobe & Kihlstrom, 1997). In addition, proponents of this view hold that traumatic memories, on account of their vividness (which nobody disputes) are more likely to be accurate (which is highly disputable).

This view is at odds with some of the data on eye-witness memory. In a situation in which a person is pointing a gun at another person, a weapon focus is most likely to occur (Loftus, 1979). A person so menaced is much more likely to be focussed upon the weapon than upon the person holding it. In such a situation, the odds are that while memory of this event is likely to remain highly vivid over a prolonged period, it may still be grossly inaccurate.

The issue of memories "recovered" in psychotherapy has become controversial in an unexpected way. Some see it as an attack

on all psychodynamically oriented clinicians who seek to understand a patient's current difficulties in terms of his/her past experience. In actuality, RMTs subscribe to a very distinct viewpoint that is at variance with the general clinical consensus -- they believe that all human distempers, from abulia to zoophilia, are the products of repressed memories of sexual abuse by a parent during childhood.

Given that the effects of sexual abuse are highly variable, it would come as no surprise if it were found that a background of childhood sexual abuse is implicated in at least a proportion of cases diagnosed in every known clinical syndrome. The argument by RMTs that it is implicated in all cases of the various diagnosable disorders is, however, an overstatement of the case. It is in this search for a unitary, single cause of all human psychic distresses which singles out RMTs from the mainstream of clinical practice, particularly those who seek to explore a patient's past with no specific expectation of encountering incest. It is one thing to believe that present difficulties stem from past experience and that they can best be treated by having the patient recall these earlier events. This is very different from maintaining that repressed memories of childhood incest explain all psychic distresses.

How can a person find a qualified clinical practitioner of hypnosis?

In most cities, the Yellow Pages of the telephone book carry a listing of "Hypnotists" or "Hypnotherapy." While this should make finding an appropriately trained clinician of hypnosis relatively easy, in fact, it does not. In these pages, professionals in Medicine, Psychiatry, Psychology, and Social Work are lumped together with individuals who have no such formal training -- that is, with what are called lay hypnotists.

The issue of formal training in one of the helping professions is important; on a probabilistic basis alone, a professional who has a grounding in one of these fields is more likely to provide a high level of competent assistance. In addition, there are legal ramifications -- if a client/patient is dissatisfied with the treatment program offered, it is usually a relatively simple and inexpensive matter to file a complaint with the appropriate professional society. If the subject of a complaint is a lay hypnotist, the only way of obtaining redress is through a court of law. In many cases this will prove to be both time-consuming and expensive. A further difficulty in finding a properly qualified clinician who is trained in hypnotic procedures is that many of the lay hypnotists confer upon themselves and each other official sounding names, titles and letters after their names; some even designate themselves as "Doctor," or "Professor." These letterings after the name and pseudo-titles imply a legitimacy that, usually, does not exist. The Bulgarian Institute of Hypnosis or the Norwegian College of Hypnotherapists, for instance, could be the name of a legitimate professional practice, but it could, as equally, be the name of a lay hypnosis organization.

Ordinarily, though, in most cities the local branch of a national professional society of hypnosis lists itself in the Yellow Pages of the telephone book and, most importantly, it offers information about who is qualified to practice hypnosis clinically, while not itself offering a treatment program. In most cases, it lists itself as a society (such as the Mexican Society of Hypnosis or the Japanese Society of Hypnosis). A few careful telephone inquiries should, ordinarily, elicit the desired information about who is qualified to practice professionally in a particular region.

Asking questions about whether a particular society is affiliated with the International Society of Hypnosis (ISH), and/or the European Society of Hypnosis (ESH) [see the [next section](#)], and the degree(s) required to be a member of a particular regional society are sound methods of establishing the bona fides of a particular organization.

Alternatively, a person who is interested in being treated by hypnosis can always consult a physician, psychiatrist, clinical psychologist, dentist or social worker, depending upon what the problem is. Most professionals in these fields do not, themselves, employ hypnosis as a treatment modality, but they often can refer clients to a qualified person, though not all do. In a few cities, qualified professionals refer patients to lay hypnotists -- at least according to some lay hypnotists. Again, given that the practice of lay hypnosis is legal in most countries, the only remedy, though unsatisfactory, is for the patient to insist that the referring professional disclose the hypnosis practitioner's credentials.

This emphasis on credentials may appear overly severe, and it does not always result in the desired effect, which is treatment from a highly trained, ethical and caring professional. But many of the same considerations are involved in choosing a family physician, dentist, lawyer and plumber. The difference is that the techniques of hypnotic induction are easily mastered, thus making it possible for virtually anyone to designate him/herself as a "hypnotist." By contrast, self-trained professionals in medicine, dentistry, law and plumbing are comparatively rare -- though documented cases (particularly in law) exist.

What are the main professional hypnosis societies?

At the professional level, hypnosis is structured in terms of two international societies (The International Society of Hypnosis (ISH) and the European Society of Hypnosis (ESH) and their constituent national societies. ISH is headquartered in Melbourne, Australia. It has approximately 1800 members, and since 1967 has been holding an international congress every three years in different parts of the world. For instance, the 1997 congress was held in San Diego, USA, while the 2000 congress will be held in Munich, Germany.

There are national societies of hypnosis affiliated with ISH in Australia, Austria, Belgium, Brazil, Canada, England, Finland, Germany, Hungary, India, Ireland, Israel, Italy, Japan, Mexico, The Netherlands, Norway, Scotland, South Africa, Sweden, Switzerland and the United States. Most of these 22 constituent societies hold annual meetings which are open only to appropriately qualified members. On occasions, though, a meeting open to the public may be organized as part of the conference proceedings.

The European Society of Hypnosis (ESH) is a more recent development; it has been meeting every three years since its inaugural convention at Malmo, Sweden in 1978. According to one of its founding fathers, it has approximately 7,000 members and 27 constituent societies. These are in Austria, Belgium, Denmark (2), England (2), France, Germany (3), Hungary, Israel, Italy (2), Finland, Lithuania, The Netherlands, Norway, Poland, Rumania, Russia, Scotland and Switzerland.

What are the main scientific journals of hypnosis?

There are several national journals of hypnosis. **The International Journal of Clinical and Experimental Hypnosis** is published four times a year by the Society of Clinical and Experimental Hypnosis (SCEH). It is the longest running journal in the entire 200+ years history of hypnosis, having published its first issue in 1953. The current Editor is Michael R. Nash, Ph.D. of the University of Tennessee. A second American society, the **American Society of Clinical Hypnosis (ASCH)** has also been publishing four times a year since 1958; its current Editor is Edward R. Frischholz, Ph.D.

The Australian Journal of Clinical and Experimental Hypnosis has been published twice a year since 1972 by the Australian society of Hypnosis (ASH). Its current Editor is Barry J. Evans, Ph.D. of the University of Melbourne. **Hypnos**, which began publishing in English in 1973, is the journal of the Swedish Society of Clinical and Experimental Hypnosis and doubles as the official journal of ESH. Its current editor is Bo Forslind, M.D., Ph.D.

Contemporary Hypnosis has been published since 1983 by the British Society of Experimental and clinical Hypnosis (BSECH). Its current Editor is David Oakley, Ph.D. of University College London.

All of these journals publish in English although Hypnos provides abstracts in Swedish, and the International Journal of Clinical and Experimental Hypnosis carries them in French, German and Spanish. By contrast, **Experimentelle und Klinische Hypnose**, published since 1984 by the German Society of Hypnosis, is written almost entirely in German. Its current editor is Walter Bongartz, Ph.D. of the University of Konstanz.

In addition, The Milton Erickson Society of Clinical Hypnosis (M.E.G.) in Germany publishes a twice-yearly journal called **Hypnosis and Cognition**. It is co-edited by Burkhard Peter, Ph.D. and Christoph Kraiker, Ph.D.

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