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Issues in the Detection of Those Suffering Adverse Effects in Hypnosis Training Workshops

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Enhancing safety in hypnosis workshops is an issue of significant concern in the progress and promulgation of hypnosis as a facilitator of treatment. In general, hypnosis is a safe modality, but occasional adverse effects are encountered in its use in clinical, research, and professional workshop settings. To develop and implement modifications designed to reduce the number and/or severity of such unfortunate incidents in workshop settings, it is necessary to establish an awareness of the nature and implications of these adverse events. This article describes 9 categories of problem presentations known to have been generated in workshop settings. It also discusses a particular constellation of factors that—without imputing blame to either faculty or to workshop participants—creates powerful forces that minimize the likelihood that adverse effects will either be recognized by faculty or reported by workshop participants.

Keywords: hypnotic ability, hypnosis complications, hypnotic depth, hypnotic sequelae, hypnotic training, hypnosis workshops

It has long been known that adverse or unwanted effects may accompany the use of hypnosis. E. R. Hilgard (1965), J. R. Hilgard (1974), and others found unwanted responses in a significant minority of subjects undergoing research hypnosis. Most effects were transient and without major adverse consequences, but some serious sequelae were

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I acknowledge with gratitude the constructive criticisms of earlier versions of this article offered by Edward Frischholz and Stephen Lankton. I am deeply grateful to a number of people whose ideas and observations have enriched my perspectives in pursuing the study of workshop safety. Here I list them in alphabetical order. I apologize to many others I have spoken to about these matters over the years, whose names have escaped my memory, or whose remarks impressed me, but whose names I never knew. This is not the list of those with whom I discussed in depth the particular issues studied in this communication: Eva Banyai, Ph.D.; S. Ami Berkowitz, M.Ed.; Peter B. Bloom, M.D.; Bennett G. Braun, M.D., M.S.; Ira Brenner, M.D.; Guiseppe di Benedittis, M.D., Ph.D.; Etzel Cardena, Ph.D.; Sherryll Daniel, Ph.D.; Dabney Ewin, M.D.; Catherine G. Fine, Ph.D.; Stephanie Fine, Psy.D.; Edward J. Frischholz, Ph.D.; Marcia Greenleaf, Ph.D.; Daniel Handel, M.D.; Hedy Howard, M.D.; Stephen Kahn, Ph.D.; Richard J. Loewenstein, M.D.; Tom Nagy, Ph.D.; Donald Nathanson, M.D.; Stephen Pauker, M.D.; Max Shapiro, Ph.D.; David Spiegel, M.D.; Herbert Spiegel, M.D.; Onno van der Hart, Ph.D.; Eric Vermetten, M.D., Ph.D.; Bhaskar Vyas, M.D., Ph.D.; David Wark, Ph.D.; Linda M. Young, M.D.

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encountered. This literature was reviewed thoroughly by Gruzelier (2000) and selectively by Kluft (2010, 2011a). Between 16% and 33% of those tested with classic hypnosis scales suffer adverse effects (Gruzelier, 2000; E. Hilgard, 1965; J. Hilgard, 1974; J. Hilgard, E. Hilgard, & Newman, 1961). Between 4% and 8% of subjects experiencing newer scales suffer adverse effects; some instances are severe (Cardena & Terhune, 2009). Incidences of adverse effects reported in various studies range widely. Comparing rates across studies is problematic because of differences in the tasks included in various hypnosis scales, the definitions of adverse effects, and the topics of research inquiry.

MacHovec (1986) reviewed clinical accounts consisting largely of anecdotes. Adverse effects are encountered in hypnosis-facilitated treatments of psychological, psychophysiological, and/or medical conditions. Stage hypnosis is associated with a higher likelihood of negative sequelae than research or clinical hypnosis, despite the fact that some studies report higher frequencies in research settings. MacHovec (1986), for instance, estimated that 7% of those who experience therapeutic hypnosis and 15% of those who experience stage hypnosis may suffer adverse reactions. Echterling and Emmerling (1987) found adverse sequelae in 20% of those participating in stage hypnosis. Again, many factors render accurate comparisons problematic.

These contributions notwithstanding, the literature is virtually silent with regard to adverse consequences of hypnosis in workshops for the training of health and mental health professionals in the use of hypnosis. Mott (1992) noted four categories of hypnosis in his study of adverse effects: research hypnosis, clinical hypnosis, amateur hypnosis, and stage hypnosis. Lynn, Myers, and Mackillop (2000) studied research, clinical, and stage hypnosis. However, both studies overlooked hypnosis in training workshops. Findings associated with one setting cannot be assumed to apply in another (Mott, 1992).

Workshop participants often experience hypnosis on several occasions over a rather brief period of time. Incidentally, if it is true that the ranks of health and mental health professionals include many drawn to these professions by their own difficulties and conflicts, many may be at increased risk by the nature of those difficulties and conflicts (especially to the extent they may be still unresolved).

Between 2001 and 2004, three colleagues who suffered severe adverse consequences came to my attention after participating in well-planned hypnosis workshops taught by skilled and experienced faculties. Their experiences challenged a perspective I had accepted without question for more than 30 years—that hypnosis training is a safe and benign situation. Studying these casualties, I inadvertently stumbled upon previously unexplored concerns. Had such adverse effects been present but overlooked? If so, how had this come to pass, and what can be done? To answer these questions, it would be necessary to better understand what transpires in workshops, obtain reports of workshop casualties as they became available, discern how to best identify the antecedents and onsets of such situations, and develop ways to intercede before problems developed or escalated.
Method

Discovery of Index Cases

I had no preexisting interest in the issue of workshop safety. Encounters with my three index cases, reported elsewhere (Kluft, 2008, 2009), were serendipitous and shocking. They can be briefly summarized as follows.

Case 1

A young colleague became upset when I mentioned considering hypnosis in her treatment. She had taken a basic workshop in hypnosis. She reported that she experienced difficulty becoming realerted in that workshop. At the time, she received reassurances that she would awaken at her own pace. She reported that a male participant noticed her situation and bombarded her with seductive suggestions. He nearly succeeded in raping her. Later, her therapist, under the guise of using hypnosis to remove any residual trance, induced hypnosis, deepened her trance, disoriented and confused her, raped her, and suggested she would recall nothing. These abhorrent situations did not raise concerns about workshop safety immediately. Instead, issues of sexual exploitation and its sequelae arrested my attention.

Case 2

Less than a year later, I tried to assist a colleague who became flooded with memories of overwhelming traumatic scenarios triggered by imagery used in her basic hypnosis workshop. She had not become fully realerted after her first hypnotic experience. During her second, she drifted into painful traumatic material she could not contain. She became suicidal but concealed her anguish in the workshop. The faculty did not notice her distress. I saw her on an emergency basis when she returned from the workshop, elicited a safety contract, and scheduled follow-up sessions daily. Nonetheless, she took her life before returning.

Case 3

One year later, a colleague with whom I had been discussing Cases 1 and 2 informed me that the colleague’s child had just returned from a basic workshop in hypnosis and suffered disruptive adverse consequences. I interviewed this younger professional and offered support. Realerting after the first hypnotic exercise had been unsuccessful. This participant’s distress was apparent to faculty and fellow participants. Initial faculty reassurances proved ineffective. Additional interventions, ill-suited to this individual, caused further complications. She suffered prolonged distress.

Now I no longer could consider the workshop setting benign. I had to wonder whether events with potentially profound negative consequences might develop and escalate to
problematic proportions in workshop settings without being noticed or raising concern. Was it possible that such events had been overlooked (a) because we assumed that if adverse effects were occurring they would be reported or call attention to themselves, (b) because we had neither an adequate index of suspicion that they might be happening nor an adequate searching image to guide our efforts to recognize them, or (c) because less than full realerting was being accepted as adequate by many teachers of hypnosis? Could one or more of these factors have had the potential to inadvertently place and leave participants in ongoing states of increased vulnerability? Reporting my concerns to the workshops’ sponsors, I wondered whether what I had encountered was consistent with the experience of respected colleagues or just an accidental cluster of individually unlikely events.

Conversations With Colleagues

I discussed my observations and concerns with colleagues in the United States and abroad and inquired if they observed anything about the behavior of workshop participants after trance experiences, including adverse consequences of hypnosis in workshop settings. This process involved lengthy discussions with more than 30 colleagues and brief conversations with many more.

Observations of (Primarily Basic) Workshops

I observed and/or taught in basic and advanced workshops given by two major American hypnosis societies and a local hypnosis society, averaging 2–4 workshop observation opportunities per year between 2005 and 2011. In total, I observed more than 70 hypnotic exercises in basic workshops (e.g., small group practices, demonstrations, group hypnosis) and more than 40 in advanced settings.

Interviews With Colleagues Reporting Adverse Experiences Associated With Hypnosis Workshops

Giving talks about workshop safety, I began to hear from colleagues who had suffered or observed serious adverse effects in workshops. Over a period of 5 years, two dozen colleagues shared reflections on their own experiences. Three others actually approached me at meetings fresh from such experiences earlier that same day and asked for help in regaining their equilibrium. Including the index cases, I collected a total of 30 first-person accounts of workshop-related adverse experiences.

A Focused Inquiry

I needed to learn whether members of the American Society of Clinical Hypnosis (ASCH) and/or the Society for Clinical and Experimental Hypnosis (SCEH) were
inclined to either report discomfort in workshops or keep workshop discomfort to themselves. I presented a single fixed-choice question to members of ASCH, SCEH, or both who had not suffered adverse workshop experiences. This sample consisted of the first 25 individuals I encountered after the summer of 2009 who had been members of one or both societies for more than 10 years and who had taught in their basic workshops. The question asked, “If you were attending an ASCH or SCEH workshop as a participant, not as a faculty member, and you began to experience severe distress you understood to be psychological, would you report this to the faculty or attempt to contain your distress to deal with it elsewhere?” The outcome of this inquiry is subsequently reported.

Work With the Howard Alertness Scale

Hedy Howard (2008) shared her ongoing efforts to develop an instrument to permit a more accurate appreciation of the impact of realerting efforts. Knowing that assessing the presence or absence of hypnosis with a brief, user-friendly instrument would be fraught with conceptual and pragmatic difficulties, Howard (2008) reformulated the problem as one of determining whether a benchmarked prehypnotic baseline degree of alertness had been reestablished by the realerting process.

The Howard Alertness Scale (HAS) (2008) asks the subject (a) to attend to his or her experience of certain sensations and perceptions before the induction of hypnosis and (b) to make a global estimate of baseline alertness, reported on a 10-point Likert-type scale ranging from 1 (very low alertness) to 10 (very high alertness). After dehypnosis, the subject is asked to rate his or her sense of alertness compared to the benchmarked experiences. Baseline assessments can be administered in just over a minute; follow-up estimates take only seconds.

Currently being researched to explore reliability and validity, the HAS has already proven to be a useful clinical tool. In my explorations, I used HAS questions, but followed whether the specific benchmarked indicators of baseline experiences had been restored rather than eliciting numerical estimates.

Results

Findings From Preliminary Inquiries

Conversations With Colleagues

At North American and overseas meetings, I consulted with more than 30 distinguished colleagues. Hypnosis teachers worldwide had observed the phenomenon of workshop participants not making complete exits from trance. While most officially regarded workshop casualties as rare or even nonexistent some went on to confide “war stories” of serious problems in workshops. These accounts usually involved
spontaneous abreactions during hypnotic exercises and instances of refractory trances from which participants had been difficult to realert. Therefore, my observations were consistent with familiar phenomena that had been observed by others but remained unreported.

**Participant Observations in Workshops**

Realerting efforts received particular attention because my index cases had experienced difficulties in realerting before the onset of their severe difficulties. In general, I observed that early in basic workshops directive dehypnosis efforts were common, but they soon gave way to more permissive approaches. Thereafter, permissive efforts prevailed. Subjects in group exercises and practice groups were commonly observed to appear somewhat spacey after permissive dehypnosis. An occasional faculty member would ask follow-up questions of dehypnotized subjects and make additional interventions if unsatisfied by a subject’s state of alertness, but the usual approach to the matter of residual trance was to offer reassurance that persistent unwanted effects would resolve rapidly, or when the subject’s mind was ready for this to occur. Most apparently responded, but some appeared to remain entranced. Several subjects told me that they had remained spacey from the morning’s first hypnotic experience through the remainder of the day. In experiential advanced workshops, tolerance for remaining in a degree of residual trance was surprisingly high among participants and faculty alike. Advanced participants often remarked that these residua were characteristic of their hypnosis experiences and that they caused them no distress. My observations were consistent with the scenarios described by my index cases and their successors; that is, there is widespread tolerance of incomplete realerting as an acceptable degree of realerting, and it is relatively infrequent for faculty to intervene unless the incompleteness of realerting becomes conspicuous. Workshop participants might be allowed to remain in states with some indications of trance residua for protracted periods of time, and begin subsequent hypnotic experiences already in some degree of alert trance.

**Interviews With Colleagues Reporting Adverse Experiences**

Twenty-seven additional colleagues shared their experiences. After listening to their freely offered accounts, follow-ups were conducted with additional inquiries based on my study of the index cases to be sure interviewees had shared the nature of their subjective perceptions of the unwanted negative circumstances, indicated whether they had reported their experiences to the workshop faculty, communicated their best recollection of whether their situations were noticed by faculty or peers, stated their best recollections of what, if anything, was done by those with awareness of their situations, and informed me of how their adverse experiences were resolved (if they were resolved). I never asked for additional information about unpleasant mental contents, but I listened
if it was offered. Two of the first three index cases had immediately reported their situations, but one of the three and none of the 27 subsequent cases had done so. A handful stated that they had not come out of trance completely, had received simple or bland reassurances, and abandoned further efforts to communicate their distress. If their experiences were shared afterwards it was rarely shared with workshop faculty. Every one of the 27 stated they had not become completely realerted from their hypnotic experiences before the onset of the adverse event. This was striking when reported by the three index cases (Kluft, 2008, 2009) and powerfully disconcerting when reported by 27 additional individuals. It appears that if participants are not realerted completely, their subsequent trance experiences may build upon a baseline of residual trance and create an inadvertent de facto deepening analogous to the fractionation method of Vogt (Kroger & Yapko, 2008), in which one trance is induced after another in order to build upon its predecessors to create deepening. It seems possible that inadvertent deepening occurs and progresses unrecognized by operator and subject. This may explain why some participants descend, apparently precipitously, into distressing dysphoria and disorganization.

Results of a Focused Inquiry

Every one (100%) of 25 members of ASCH, SCEH, or both, asked whether they would report personal distress in a workshop setting or keep their situations to themselves, stated that they would keep their distress private. While the colleagues who did not share their distress may differ from the majority of the members of these two societies in many ways, in the matter of preferring to keep their distress to themselves, they are typical.

Work With the Howard Alertness Scale (HAS)

A vignette in which I responded to an unanticipated request to demonstrate this instrument to a group of colleagues illustrates the potential of HAS. I became familiar with Howard’s (2008) methodology before it was put in the form in which it was published. While addressing a local hypnosis society about enhancing workshop safety, I emphasized the need to recognize and address instances of inadequate dehypnosis, and expressed my positive opinion of Dr. Howard’s work. I was asked to demonstrate how Howard’s (2008) ideas could be applied, and techniques for dehypnosis. All present identified themselves as good hypnotic subjects. I asked them to benchmark their prehypnotic senses of themselves using the major inquiries of the Howard Alertness Scale, did a brief induction, and offered permissive suggestions for a pleasant and enjoyable experience. Then, I used permissive realerting suggestions, drawn verbatim from a recent basic workshop handout.

Most of the 17 or 18 participants appeared to exit trance smoothly and rapidly. Five took a few minutes before indicating they were alert. Another remained dramatically stuck in trance. By this I mean that despite his clear efforts to realert himself, he could
not do so. After witnessing 8–9 minutes of unsuccessful efforts, I intervened. Permissive
dehypnosis suggestions had failed him, but a directive method achieved apparently
successful arousal.

With all participants apparently realerted, all affirmed they now felt completely alert.
Their subjective assessments of alertness were based upon an absence of the sense of
being in hypnosis. I now asked them to compare their subjective posthypnotic states
with alertness understood as HAS benchmarked prehypnotic perceptions. Using HAS
criteria, now only two affirmed that they had successfully returned to their benchmarked
degrees of alertness. Directive methodologies were applied until all participants were
restored to their benchmarked states. Those present were shocked by the startling dis-
crepancy between how they had reported their subjective perceptions of being out of
hypnosis and their subjective perceptions of their degrees of alertness. Had I omitted
the HAS inquiries, relied upon my colleagues’ subjective assessments of their alertness
in terms of being out of hypnosis, and made no further efforts to address their incom-
plete realerting, 15 or 16 colleagues would have left this meeting at 10:00 p.m. and
driven home in various degrees of waking trance. The HAS, now in the process of being
researched objectively, shows initial promise as a method to identify residual trance in
those whose incomplete realertness is not immediately apparent to either observers or to
themselves.

Findings Related to the Detection of Risk for Adverse Effects or Incipient
Adverse Effects

The aforementioned findings were developed in the service of my efforts to describe
phenomena indicative of the occurrence or the incipient development of adverse effects.
While two of my index cases had demonstrated signs of distress in the workshop
setting, the third, who committed suicide, had not. I initially believed that the third sit-
uation was atypical. My findings, however, refuted this assumption. Overall, 2 of my
30 interviewees (7%) were overt, but 28 or 30 (93%) were covert or undisclosed.

Presentations in the Workshop Setting of Adverse Effects of Hypnosis as
Revealed by 30 Informants

Interviews with 30 colleagues who suffered adverse effects and described both the
private and public manifestations of their difficulties make it possible to develop a ten-
tative classification of the presentations of their difficulties. The classifications listed in
the Appendix, and that are subsequently discussed, describe unwanted events in ways
that emerge from the interview data and are meant to sensitize workshop faculty to what
may be occurring in their workshops. It differs in purpose from, but is not inconsis-
tent with, more familiar classifications of adverse events (e.g., MacHovec, 1986), as
TABLE 1
“Presentations” of Potential or Actual Workshop Casualties

1. Failures to alert resulting in persistent or residual waking hypnosis with diminished Generalized Reality Orientation (GRO) (Shor, 1959) and/or enhanced suggestibility or uncanceled posthypnotic suggestions that are not recognized by subject, peers, or faculty
2. Difficulties in realerting noted by peers or faculty +/− by subject
3. Difficulties in realerting noted by subject and
   a. Shared
   b. Withheld
4. Distress/dysphoria (including psychophysiological and/or somatoform) noted by peers or faculty +/− by subject
5. Distress/dysphoria (including psychophysiological and/or somatoform) noted by subject only and
   a. Shared
   b. Withheld
6. Abreactions and/or intrusions of BASK (Behavior, Affect, Sensation, Knowledge) elements (Braun, 1988)
   a. Noted by peers or faculty
   b. Withheld in workshop
      i. Shared later
      ii. Kept private
7. Behavioral abnormalities caused by residual suggestions
8. Disinhibition of dissociative or psychotic processes
9. Phenomena caused by peer or faculty error or malfeasance facilitated by hypnosis but not intrinsic to hypnosis per se

subsequently discussed. A full list of presentations noted during this research appears in Table 1.

Presentation 1. Difficulties in Realerting Unrecognized by Both Subjects, Peers, and Faculty

Failure to return to the pretrance waking state is probably the most common adverse response. This is noted only by chance or when deliberate attempts are made to elicit indicators of residual trance. A state persists which might be characterized as alert hypnosis or a hybrid of residual trance. It was illustrated by 15 or 16 (89%) members of the hypnosis society who had not demonstrated overt failures of dehypnosis, but who failed to return to their HAS pretrance benchmarks, potentially indicating unsuspected incomplete realerting despite self-reports of successful dehypnosis.

Presentation 2. Difficulties in Realerting Noticed by Self and Others

Difficulties in realerting was observed in the individual at the hypnosis society who had remained in trance, and six others who took several minutes to reach a state they identified as being out of trance. Groggy after permissive realerting, they rubbed their eyes and foreheads, yawned or stretched, or got up and walked around before sitting down. Two shook their heads vigorously. One did an eye roll, closed his eyes, and then reopened them, smiling and appearing alert. I infer he used a rapid induction (Spiegel & Spiegel, 2004) and restructured and terminated his trance.
Presentation 3. Difficulties in Realerting Noted by the Subject Only, Shared or Withheld

On her way to coffee break, a female colleague approached me, amused and anxious. “You taught us we should tell you if we couldn’t get back completely from trance.” She said she felt very well but knew that she “just wasn’t back” to her baseline self. Her sense of herself “just wasn’t right.” “English is not my first language,” she mused. “I find myself thinking in Spanish, and not finding my way back into English.” I suggested that she count herself out of trance in Spanish. She succeeded rapidly. I advised her to repeat subsequent dehypnosis instructions to herself in Spanish, which proved effective according to her self-report.

Presentation 4. Distress or Dysphoria Noted by Peers or Faculty

I participated in a workshop wherein the leaders were fastidious about realerting participants during the first few exercises. Thereafter, participants were to realert themselves. Left to her own devices, a colleague to my left began to show signs of distress and worsened with each exercise. Concerned, I spoke to her. Certain imagery had triggered traumatic flashbacks and while these were similar to familiar material, they were previously unknown to her. Working together unobtrusively with whispers and notes, I helped her contain the situation and realert completely.

Presentation 5. Distress Noticed By Subject; Presentation 8. An Abreaction Begun in a Workshop, Unnoticed by Others

Communication after the fact is the most common overt presentation of adverse effects. Nothing is said at the time of the workshop demonstration. Five years after I taught deepening techniques in a workshop, a participant provided the following feedback. As she had reached the bottom of the flight of stairs I had used in deepening imagery, she abruptly remembered being thrown down the cellar steps by her father and raped at the foot of those steps. She suppressed her reactions until the end of the day, did not return to the workshop, and for some time avoided hypnosis-related meetings. Three years of intensive psychotherapy were necessary before she recovered a reasonable quality of life.

Presentation 6. Behavioral Abnormalities Caused by Residual Suggestions

Problems caused by inappropriate suggestions are usually associated with the innocent errors of beginners, with the psychopathy of an operator, or with what might be called narcissistically driven overreaching efforts by a faculty member. Some unfortunate suggestions were designed to be helpful, and some served inappropriate agendas or
the personal needs and/or self-esteem of a faculty member. Extreme psychopathic examples have been previously cited, a narcissistic example is offered later. I subsequently present a more typical instance that is unrelated to workshop concerns.

More than 40 years ago, a neophyte in hypnosis, I learned that a downstairs neighbor was ill, already dehydrated by a fulminating gastrointestinal illness. Her eye roll (Spiegel & Spiegel, 2004) was 4+, the highest possible score. I offered to help her calm the overactivity of her bowels. This intervention achieved dramatic success. I was then too naïve to anticipate that a suggestion useful at one moment might prove problematic in the future. Four days later my neighbor called, grateful, but requesting help because she had not been able to move her bowels since my intervention.

**Presentation 7. Disinhibition of a Dissociative or Psychotic Process and Distress/Dysphoria Noticed by the Subject**

The suicide of a colleague abruptly overwhelmed by traumatic material was previously noted. One of the three colleagues who approached me on an emergency basis faced a similar challenge. She was impressed by the skill and artistry of the director of an advanced workshop but upset by this person’s infatuation with her own imagery, which triggered vivid flashbacks of the colleague’s abusive childhood. Using her considerable autohypnotic skills to contain her escalating distress and withstand traumatic flashbacks she kept the traumatic material at bay for the moment. However, during a second exercise she became deeply absorbed in the imagery and her own defensive efforts and could not exit trance completely in response to permissive instructions.

Another participant protested that she had not become completely realerted. The director minimized that participant’s complaints and offered perfunctory reassurance. No interventions were made. Witnessing this, she concluded it would be pointless to report her own situation. She faults herself for not leaving at this point. In retrospect, she feels she overestimated her ability to protect herself with her autohypnotic skills, and mistakenly prioritized her pride in not being a quitter. Fully aware she had never exited trance, she continued with further exercises. Last, her already strained defenses and autohypnotic resources were overwhelmed. She plummeted into a personal hell of previously unknown traumata. Concealing her pain, she hoped to connect with a close friend at lunch. When this plan failed, she turned to me for help.

Her situation proved complex and serious. She was suicidal, and a discrete ego state was associated with the traumata in question. I faced the challenge of stabilizing a suicidal colleague with a newly discovered dissociative disorder on an emergency basis. A spontaneous abreaction began, during which she tried to throw herself out of a window. After several hours of vigorous abreactive work, the emerging traumatic memories and their associated affects and ego states integrated. Her rage at the workshop director required further extensive processing as well.
Presentation 9. Phenomena Caused by Peer or Faculty Error or Malfeasance Facilitated by Hypnosis but Not Intrinsic to Hypnosis Per Se

This type of malfeasance or error occurs whenever the faculty/participant power differential is used to override the free will of the participant, and/or when interventions are made that seem to serve the purpose of the faculty member or a peer rather than of the subject. Extremely abusive examples were previously noted. Here I present an error of my own.

Until 2004, I prided myself that virtually every member of every small group practice I had led participated in every exercise. I believed, and tried to convince participants, that optimal learning required complete immersion. I never recognized an adverse consequence from this approach, somehow isolating away that I had witnessed numerous situations in which other faculty members imbued with the same ideal had pressed students too far, with unfortunate consequences. Given what I have learned doing this study, I now respect participants’ misgivings and accept their concerns at face value. Pressure and shaming are destructive, and were implicit in the stance I abandoned. It is important to appreciate that the classic shame posture of downcast eyes and a bowed and averted head (Nathanson, 1992) is so familiar to the hypnosis world as the typical relaxed posture of a person in trance that it is easy to misunderstand or fail to consider manifestations of shame in a hypnotic subject.

In basic hypnosis courses, in addition to conventional signs of distress, I look for signs of fatigue, mild confusion or befuddlement, and shame. Participants whose heads are not erect when they are not involved in a hypnotic exercise draw my attention. Most will prove simply to be fatigued or suffering a chronobiological low. But I will continue tracking their behavior as the day goes on. Are they still in trance? Are they unsettled? Are they inwardly preoccupied with the business of containing themselves and blocking out external stimuli? Are they having experiences that cause them to think poorly of themselves?

The latter is more common than one would suppose among those who seek hypnosis training, and discover either that they cannot handle trance well or are unable to experience many of the phenomena suggested in the inductions and exercises. Hypnosis workshop faculty members I have observed often make the error of relying upon the use of visual imagery they find agreeable or congenial throughout a workshop. Yet, apparently benign visual imagery has been seen as highly associated with adverse effects (Gruzelier, 2000), prone to be triggering (Orne, 1965), and leading to problematic associations. Also, visual imagery may fall outside the skill sets of some otherwise good hypnotic subjects who, confronted with a training program that requires a skill they lack for meaningful participation, may become frustrated and disenchanted with hypnosis as it is presented to them.
Discussion

The findings in this study demonstrate that despite their absence from the literature, adverse responses to hypnosis do occur in workshop settings and should not be considered to be rare occurrences. Although these observations were conducted in the United States, colleagues in many other nations confirm that they have observed similar phenomena. This suggests that the findings shared here may have general relevance.

The adverse responses reported here are, for the most part, subjective experiences with minimal external manifestation of the inner pain and turmoil being experienced. Usually they are not reported. A combination of pervasive professional belief that workshops are safe environments, inattention to the possible detrimental unintended consequences of accepting incomplete realerting as if it were adequate realerting, utilizing imagery approaches which are often assumed to be benign and universally acceptable, plus an overvaluing of permissiveness in matters of technique combine to create a situation in which some participants can enter a process of unrecognized deepening and enhanced vulnerability to some misadventure, and may remain in such a state for a protracted period of time.

These oversights are all the more striking because although it is well-known that single hypnotic experiences involve the risk of adverse consequences, workshop participants, especially in basic and experientially based advanced workshops, are virtually bombarded with numerous hypnotic experiences over a relatively brief period of time. Workshop participants’ exposures dwarf the hypnosis exposures of research or stage hypnosis subjects, yet they have not generally been considered a group at risk for adverse reactions to hypnosis.

This denial is all the more problematic because to the extent that health care professions may attract many who themselves have suffered painful experiences and mistreatment, we should expect individuals with histories of trauma to be present in any training offered within the healing disciplines. Hypnosis workshops hold the potential to place traumatized individuals at risk not only for immersion in their own already familiar painful mental contents, but also for the undoing of previously intact dissociative barriers and the disinhibition and weakening of defensive structures. The potential exists for putting vulnerable participants at risk of being flooded by both previously known and previously unknown upsetting materials and affects. Our workshops must offer sufficient structure to provide better protection to the traumatized among us, and must be geared to their most potentially vulnerable cohort of participants rather than to their strongest and those who demonstrate the most enthusiasm and aptitude. As a group we need to make certain there is no institutional denial playing a role in maintaining a fiction or myth of workshop safety (Zerubavel, 2008).

Since this article approaches the study of adverse effects of hypnosis from a particular perspective designed to improve workshop safety (e.g., proper realerting), it should be emphasized that its contributions in no way replace or contradict the more familiar
classifications of known causes of misadventure in the use of hypnosis (e.g., MacHovec, 1986), which include (a) adverse effects caused by nonhypnotic factors in association with hypnosis; (b) adverse effects caused by the induction of hypnosis; (c) adverse effects caused by problematic suggestions made to a hypnotized subject; and d) adverse effects caused by hypnotized subjects’ idiosyncratic reactions to normally unremarkable and safe particular techniques and images.

For example, the adverse effects of the first index case were facilitated by hypnosis exacerbated by nonhypnotic antisocial behaviors and coercive suggestions. The adverse experiences endured by my third index case were driven by egregious errors in teaching and by the countertransference issues of a faculty member. The third index participant also was exhausted and felt too tired to participate as a subject, but succumbed to social pressures to do so. In this case the use of formulaic interventions was insensitive and suggestions and remarks that seemed driven at least in part by the narcissistic needs of a faculty member were hurtful. Also essentially nonhypnotic but linked with hypnosis were other errors in teaching in a considerable but indeterminate number of the cases studied, such as the use of imagery without keeping touch with the impact of that imagery, failure to take into account that participants might have trauma histories potentially triggered by imagery approaches, and faculty’s becoming so engrossed in imagery congenial to themselves that they persisted in elaborating it and did not attend to indicators that participants were becoming upset and/or disenchanted by materials more positively regarded by the faculty than by the workshop participants (see Presentations 5 and 8). Hirsch (2008) described professionals’ absorption in doing what is more pleasing to themselves than useful to their patients as “coasting in the countertransference.”

Adverse responses to the experience of hypnotic induction alone are commonly reported. Although I have seen such situations and published a case description (Kluft, 2011b), no pure example was encountered in my interviewees. The apparent adverse response to a single induction in Index Case 3 must be reconsidered in light of the fact that nonhypnotic social pressure had been exerted to induce this person to become a hypnotic subject against this person’s better judgment. It might be argued that all or many of the 30 adverse responses were generated by the consequences of the first experiences of induction in the workshops in question. However, because many of these first inductions/experiences were affected by problems in imagery selection and the mismanagement of realerting, it is difficult to point to the inductions alone as the primary causes of an adverse outcomes.

Adverse effects caused by problematic suggestions given after the induction of hypnosis play roles in two of the first three index cases. I witnessed many in workshops I observed, but these were transient and easily addressed. No instances of serious adverse effects based on this factor alone were among those reported here, unless we decide to categorize becoming engaged with inappropriate imagery under this heading. Although such categorization would be consistent with recent Division 30 definitions (Barnier &
Nash, 2008; Kihlstrom, 2008) of the components of hypnosis, it would blur distinctions that the mainstream hypnosis community has found useful for generations.

Adverse effects caused after the induction of hypnosis when the participant experiences an unexpected response to a suggestion or technique that is generally understood to be safe for routine use were encountered frequently, but occurred in the context of trances that had been deepened in an inadvertent and problematic manner caused by subsequent trances being superimposed on the residua of incomplete realertings. This was illustrated in Presentation 6. A colleague had reacted poorly to my using going down a stairway as a deepening suggestion. She had been thrown down a stairway and raped at the bottom of the stairwell. Early in my career, a faculty member selected me for a workshop demonstration and abruptly attempted to age regress me to a happy birthday party, never considering that the birthday celebration he had selected might have been other than happy. He instructed me to return to a party that had been cancelled when my father was hospitalized, seriously ill. I considered this faculty member misinformed and passively-aggressively refused to participate. But I was impressed that cooperation with such a mindless procedure might have caused considerable pain to a more vulnerable subject.

Many factors play a role impeding us from reaching an accurate assessment of the frequency and severity of the workshop-related adverse effects. Elsewhere (Kluft, 2008–2011) I have explored the many nonscientific conflicts that impede this process. Here, I will bypass those matters to address a factor previously unexplored in the literature which I believe is more fundamental and significant. Undiscovered, it has been “hiding in plain sight.”

Almost all of those who enter training in ASCH, SCEH, APA Division 30, or any academically affiliated hypnosis program are individuals with very high ego strength, motivated toward achievement. They have surpassed the majority of their peers in order to gain admission to highly competitive graduate educational programs and complete their rigorous demands. During their professional educations, they have become increasingly socialized to a professional role and have grown accustomed to containing their emotions and reactions, a restraint that is continuously reinforced by that aforementioned professional socialization, and by modeling by and internalizing admired members of the profession that they aspire to enter. Those trained to do psychotherapy have been further taught to contain their emotions, however strong, in the therapeutic encounter, revealing them selectively and judiciously, if at all. A premium is placed on professional decorum and maintaining boundaries. The social psychology of the therapeutic hour, supervisory session, or the training encounter pulls for containment and control before one’s peers and mentors. Failing, erring, and breaking down in front of one’s colleagues are not recommended or reinforced courses of action.

Given this, we should expect that hypnosis workshop participants generally will be protective of their self-esteem and their professional presentations of themselves, and motivated to minimize their demonstration of anything that might be perceived as having the potential to bring shame or the burden of a negative assessment upon...
themselves. Such factors bias workshop participants toward underreporting upsetting experiences, and, in turn, bias workshop faculty both toward underappreciating the likelihood of encountering those who suffer upsetting experiences. These factors bias faculty toward rationalizing and making allowances for their own deviations from best practices. When we look at ourselves, we see, or want to see, and certainly want our colleagues and patients to see, the same professional demeanor that was manifested by 28 of the 30 colleagues described earlier, including the colleague who took her life. These calm self-presentations despite inner distress should be a shock and a wake-up call to educators.

It is easy to understand why we would not expect a group as medical, dental, and mental health professionals, trained and practiced in comporting themselves as “professionals,” to manifest obvious, overt, and easily discernable manifestations of distress. They might show distress when they are caught by surprise, or if their distress is overwhelming. Furthermore, they may do so if there is implicit or explicit permission to do so and a sense that their environment supports their acting on that permission.

The aforementioned findings can be summarized in an equation:

\[
\text{Strength} + \text{Shame} + \text{Socialization} = \text{Silence}
\]

A consequence of this dynamic is that a workshop leader has few opportunities to address and interrupt potential difficulties before they become genuine (and generally private) problems. To do so steps need to be taken to identify the precursors of these problems before they assume difficult proportions. Preventive steps may be feasible because it is clear that incomplete realerting has been an etiological precursor to every adverse effect discussed in this paper. Hence the enormous importance of instruments such as the Howard Alertness Scale.

Workshop leaders should mobilize the strengths of participants and assist them in creating a set of skills, strengths, and coping strategies such that they can (a) understand, (b) identify, (c) report, and (d) remedy distress related to participating in hypnosis demonstrations and hypnosis workshops. Overlooking that may result in some participants inadvertently experiencing pain, perceiving themselves as damaged and weak, and becoming flooded with shame and humiliation as well—while remaining silent.

The elements of an assertive and proactive approach to improve workshop safety would involve (a) remediation of practices placing participants at risk; and (b) identifying those who are potentially at risk, so that they can be monitored, educated about how to keep themselves safe, assisted when necessary.

Given that incomplete realerting was a precursor to every unwanted effect suffered by the thirty colleagues who were interviewed about their experiences, it seems reasonable to work from the premise that toleration of incomplete realerting as adequate realerting is no longer acceptable. The culture within the hypnosis community that
accepts incomplete realerting as adequate must be corrected because it perpetuates a misunderstanding that can lead to dangerous adverse consequences.

Given that reassurance that incomplete alerting will complete itself without further intervention often proves to be incorrect and misleading, and may cause many distressed individuals to lose confidence in those who offer such unhelpful guidance, the cost-benefit ratio of making such statements in workshop settings is unacceptable. Instead, open discussion of the risks of incomplete realerting, instructing participants in coping strategies, and individualized conversations with affected participants are preferable strategies.

Given that permissive approaches to realerting have been associated with each of the aforementioned incomplete realertings, it seems reasonable to work from the premise that permissive approaches to realerting may not appropriate for use in basic workshops during which many participants are experiencing hypnosis and dehypnosis for the first time, or are relatively inexperienced with the experience of hypnosis. In these situations, it may be best to use directive approaches to dehypnosis instead.

Given the risk of inadvertent deepening caused by the building of one trance upon the residua of its predecessor or predecessors, it seems reasonable to work from the premise that no workshop participant should be allowed to participate in any hypnotic experience until that participant is deemed to have become completely realerted from his or her previous hypnotic experiences.

Given that responses to imagery may be unique and problematic (see Orne, 1965), it seems reasonable to insist that workshop faculty avoid the use of imagery that has not been discussed or reviewed in advance with workshop participants. To avoid embarrassment, if necessary, this might be done most readily with a checklist questionnaire.

Given that individual participants may remain uncommunicative, it would be useful for future research to study how to assess whether workshops themselves manifest indicators of dysfunctions. My observations on the situation illustrating Presentations 5 and 8 reveal the following events an observer would have noticed: (a) another participant complained about faulty dehypnosis; (b) this complaint was handled dismissively; (c) during the coffee break, several participants openly expressed concerns about how the facilitator was proceeding; (d) two participants left after the morning coffee break and two more (including the colleague under discussion) failed to return after the lunch break for a net withdrawal of 50% of the original participants. If ways can be found to make use of observable indices of workshop dysfunction, perhaps on-site interventions, however difficult to mount in a tactful and face-saving manner, can be developed to put such workshops back on track, reeducating the facilitators and safeguarding the participants. Assigning a monitor to each experiential workshop might be helpful (Kluft, in press-b).

Given that some colleagues are reluctant to acknowledge difficulties, even if doing so has potential to protect them from escalating difficulties, preventive measures that do not screen workshop participants about issues associated with loss of control and
A pilot effort to use the HAS in this manner yielded gratifying preliminary results. It was used in a 2009 workshop to socialize participants to understand successful realerting as a competency-based achievement for which coaching may be required to establish optimal expertise (Kluft & Howard, unpublished data, 2009). A preliminary version of the HAS was deployed in a basic workshop for a group of 55 clinicians, a large percentage of whom had backgrounds of childhood trauma. Participants filled out personal flowsheets on which they entered their benchmarked baseline HAS scores and indicators and recorded their scores before and after each subsequent hypnotic exercise. The course director (R.P.K.) reviewed these flowsheets after each exercise and assigned specially prepared faculty to track the vulnerable, restore optimal alertness, and teach techniques useful in self-stabilization. When indicators of possible incipient problems were found, it demonstrated that it is possible to prevent the development of anticipated severe problems by virtue of the participants’ nondefensive acceptance of prophylactic interventions (Kluft, 2009, 2010).

Implicit in employing the HAS in this manner was a process of teaching those who were about to experience hypnosis to regard the reporting of any initial adverse experiences as a constructive aspect of their hypnosis education, an aspect of what I will call the hypnoeducational alliance. Such socialization provided a powerful disincentive to a participant’s remaining silent. Every one of the 55 participants was compliant in filling out the flowsheet. None complained, and several found it reassuring.

Summary

Perhaps those who begin their clinical use of hypnosis sensitized to the recognition and interdiction of adverse effects may, by applying this awareness and knowledge in their clinical encounters, enhance the safety of clinical hypnosis as a facilitator of treatment, both benefiting their patients, and increasing the likelihood that other colleagues and patients alike will take a fresh and more favorable view of hypnosis.

This article has documented the occurrence of adverse effects of hypnosis in workshop settings, described their characteristics, and discussed how they come into existence and persist, usually in a hidden form, to the detriment of workshop participants. It has argued that because these problems are usually covert, one often must explore carefully in order to discern their presence and impact, and prepare to address their impact.

In subsequent publications, I describe techniques to effect successful dehypnosis (Kluft, in press-a), and specific suggestions to enhance the safety of hypnosis workshops (Kluft, in press-b; Kluft, in press-c). These publications are designed to promote the optimization of safety in both hypnosis workshops, hypnosis research, and in the clinical use of hypnosis.
References


