ARE RECOMMENDATIONS TO AVOID HYPNOTIC AFTERROR EFFECTS BEING IMPLEMENTED?

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Abstract
To assess whether recommendations that have been made over several years to avoid hypnotic sequelae are being implemented, a short seven-item survey was mailed to 1050 names drawn from the latest directory of the American Society of Clinical Hypnosis (1998). Of the 881 surveys that were deliverable, 60.3% were completed and returned. Results indicate that some recommendations are being employed by almost all of those currently using hypnosis, while other recommendations are being employed by a lesser, but still large, percentage of hypnosis practitioners. In many of these cases, valid rationales were cited to exclude their use.

Key words: untoward aftereffects, sequelae, precautions, recommendations

Introduction
For several decades now, untoward aftereffects of hypnosis have been reported in the literature, with some recent court cases involving stage hypnosis (for example Heap, 2000; Wagstaff, 2000) again increasing interest in their occurrence (see Gruzelier, 2000, for a recent review of the literature). The severity of aftereffects reported has varied considerably from decompensation in borderline psychotic patients (Gill and Brenman, 1959) to effects essentially equivalent to those produced by a college classroom lecture or test (Coe and Ryken, 1979; Peterson, Coe, Crockford and Decker, 1991). Frequency of aftereffects has in some instances been found to vary with the hypnotic susceptibility of subjects (Page and Handley, 1993; Coe, Peterson and Gwynn, 1995), while in other instances it has not (Brentar and Lynn, 1989; Lynn, Brentar, Carlson, Kurzhals and Green, 1992). Frequency of aftereffects has also been found to vary with the context (or population) being considered; that is, research/experimental, clinical or stage hypnosis. For example, MacHovec (1986) estimated the risk of moderate or severe effects for both research and clinical settings to be about half of that for stage hypnosis. However, others have reported the lowest rates of occurrence and severity in a research context employing college students (for example, Hilgard, Hilgard and Newman, 1961; Orne, 1965; Hilgard, 1974).

Over the years, various recommendations have been made to reduce the occurrence of sequelae. For example, in a research context employing college students, Orne (1965) recommended excluding subjects with obvious psychopathology and informing them that no treatment of any kind would be undertaken. Crawford, Hilgard and MacDonald
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(1982) emphasized the importance of rapport, dispelling myths about hypnosis, and conducting a post-hypnosis debriefing to ensure that subjects (or clients) are fully awake and alert following termination of hypnosis. Page and Handley (1990, 1993) have recommended eliminating references to aftereffects (like headaches) during inductions or dehypnosis and, following hypnosis, having individuals report back with any unusual effects that might be attributable to hypnosis. Finally, MacHovec (1986) recommended obtaining a medical/psychosocial history prior to hypnosis.

To date, a number of survey studies (for example, Auerback, 1962; Levitt and Hershman, 1963; Judd, Burrows and Dennerstein, 1986) has been conducted to assess the type and frequency of aftereffects, but none has been conducted to assess the precautions being taken by those who employ hypnosis. The purpose of the present study was to determine the extent to which those currently practicing hypnosis have adopted the recommendations above.

Method

Participants

A brief seven-item survey, along with a stamped return envelope, was mailed to 1050 individuals listed in the 1998 Membership Directory of the American Society of Clinical Hypnosis. Potential respondents were asked to indicate if they had used hypnosis within the past two years in their practice (or research). If so, they were to complete a checklist of procedures that they use prior to or following hypnosis, as well as to indicate any procedures used that were not included in the checklist. (see Table 1 for a description of the survey).

Table 1. Survey questions

Have you used hypnosis in your practice and/or research within the past two years?

Yes ☐ No ☐

If ‘No’, stop here and please return this in the enclosed envelope.

If ‘Yes’, please complete the questions below and return it in the enclosed envelope.

Check the following procedures that you personally use prior to or following hypnosis:

☐ Enquire if the subject/client has been hypnotized previously.
☐ Obtain a medical/psychosocial history that includes fears, phobias, conflicts, social problems, etc.
☐ Dispel common myths about hypnosis (e.g., ‘it involves a loss of consciousness’; ‘it involves a weakening of will’).
☐ Eliminate references to aftereffects (e.g., headache) during induction or dehypnosis.
☐ Conduct a post-hypnosis debriefing to assure complete dehypnosis.
☐ Following dehypnosis, review all hypnotic experiences with subjects/clients.
☐ Following dehypnosis, inform subjects/clients that they should report back with any unusual effects that might be attributable to hypnosis.

Please indicate on the reverse side any procedures not listed above that you personally use in your practice or research.

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Out of the 1050 surveys mailed, 169 were undeliverable due to a change of address without a forwarding address; of the remaining 881 surveys presumably delivered, 531 were returned, reflecting an excellent 60.3% response rate.

Results

Inspection of the returned surveys revealed that 109 (20.5%) checked that they had not used hypnosis during the past two years, a large number of these indicating that they had retired. The responses and percentages for the 424 completed surveys are presented in Table 2.

Table 2. Survey results from 424 completed surveys

<table>
<thead>
<tr>
<th>Question</th>
<th>Responding ‘YES’</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. previous hypnosis</td>
<td>413 (97.4%)</td>
</tr>
<tr>
<td>2. medical/psychosocial history</td>
<td>387 (91.3%)</td>
</tr>
<tr>
<td>3. dispel myths</td>
<td>417 (98.3%)</td>
</tr>
<tr>
<td>4. omit references to aftereffects</td>
<td>240 (56.6%)</td>
</tr>
<tr>
<td>5. conduct debriefing</td>
<td>366 (86.3%)</td>
</tr>
<tr>
<td>6. review experiences</td>
<td>305 (71.9%)</td>
</tr>
<tr>
<td>7. report unusual effects</td>
<td>206 (48.6%)</td>
</tr>
</tbody>
</table>

The percentage checking the ‘yes’ option ranged from a high of 98.3% for item #3 (dispel myths) to a low of 48.6% for item #7 (report back with any unusual aftereffects).

Not all participants answered the survey with ‘yes’ or ‘no’ responses. A small number of respondents wrote in comments such as ‘sometimes’ or ‘not always’. Classifying qualifying comments such as these as ‘yes’ responses resulted in only a very slight increase in the percentages listed in Table 1. Specifically, the percentages for four items (4, 5, 6, and 7) in Table 1 would increase from 0.3% (for item #5) to 4.5% (for item #6) when qualifying comments are classified as ‘yes’. In addition, 13 respondents (3.1%) reported using a release/informed consent form, and nine (2.1%) reported informing their clients that memories recalled during hypnosis are not admissible in court.

Discussion

The response rate of 60.3% was especially encouraging in terms of being fairly representative of the population of hypnosis practitioners, particularly since it has long been known that response rates for mail surveys are typically low (Frey, 1989). For example, in a review of the extant data on frequency of negative aftereffects based on anecdotal reports and clinician surveys, Lynn, Martin and Frauman (1996: 11) stated, ‘Very little can be gleaned from these data because the reference samples were far from representative, with response rates typically less than 20%’.

In the present investigation, it was found that over 90% of respondents reported obtaining medical histories, enquiring whether the subject/client had been hypnotized before, and spending time to dispel myths and misconceptions associated with hypnosis.
Most of the respondents indicated that their research or clinical protocol includes a post-hypnotic interview to assess participants’ experiences and to fully debrief subjects/clients. Roughly half of the respondents reported that they systematically eliminate references to negative aftereffects, and that they tell subjects/clients to report back with any unusual aftereffects. Omitting references to negative aftereffects may be driven by the concern that such information itself can be suggestive and possibly result in a ‘self-fulfilling’ prophesy. A small percentage (only 3.1%) of respondents stated that they formally obtain informed consent, and even fewer (only 2.1%) specifically informed their subjects/clients about the inadmissibility of hypnotically-recalled memories. While these numbers seem woefully low, caution should be used in interpreting these findings, as responses to either of these procedures were not specifically solicited. Additionally, the sample consisted of an unknown proportion of researchers and clinicians that are likely to have very different protocol requirements. Furthermore, we did not enquire among the clinicians whether forensic issues were relevant to their practice. For a recent discussion concerning differing views on informed consent, see Lynn (2001) and Frischholz (2001). In conclusion, the results from this survey indicate that a majority of respondents follow many recommendations to avoid sequelae commonly reported in the hypnosis literature.

In summary, the data support the conclusion that a good many of the recommendations listed in the survey are being used by most hypnosis practitioners and, in some cases, almost all of the time. In other instances, there exists a valid rationale for not using some of the recommendations. For example, it is understandable why one would not necessarily review all hypnotic experiences (for example, ‘I want to respect the patient’s privacy’), or wish to reframe from using the word ‘unusual’ to describe effects, which itself can be very suggestive and possibly result in a ‘self-fulfilling prophesy’.

References
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