International Handbook of Clinical Hypnosis. Edited by G. D. Burrows, R. O. Stanley, P. B. Bloom

ISBNs: 0-471-97009-3 (Hardback); 0-470-84640-2 (Electronic)

23

The Negative Consequences of Hypnosis Inappropriately or Ineptly Applied

ROBB O. STANLEY and GRAHAM D. BURROWS
University of Melbourne, Australia

Over the years there have been those who have proposed that hypnosis *per se* may pose some risks for vulnerable individuals (Meares, 1961) while others have proposed that there were no risks at all in the use of hypnosis (Le Cron, 1961). In coming to a conclusion on the issue of adverse effects one must as always consider under what conditions, by whom and with whom hypnotic techniques are being used (Stanley, 1994).

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

> Hypnosis complications are unexpected, unwanted thoughts, feelings or behaviors during or after hypnosis which are inconsistent with agreed goals and interfere with the hypnotic process by impairing optimal mental function. There is no prior incidence or history of similar mental or physical symptoms. They are non-therapeutic . . . or anti-therapeutic. (MacHovec, 1988, p. 46)

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

ADVERSE EFFECTS OF THE EXPERIENCE OF HYPNOSIS

Early concerns about the possible adverse effects of hypnosis were related to the issue of volitional control and the potential for the hypnotized subject to act in ways in which they would not otherwise behave or accept. In particular, concern

focused on the commission of criminal offences and the alteration of volitional control in the many cases of sexual abuse and seduction that had come to the attention of the authorities. These concerns were expressed as early as 1784 by the Commission to Investigate Mesmerism set up by the French Government.

The issue of volitional control and hypnosis is beyond the scope of this chapter. It is sufficient to comment that the answer to the question 'can subjects be caused, as a result of hypnosis, to act in ways that they would find unacceptable or potentially harmful to themselves or others?' remains equivocal. 'Maybe yes, maybe no' seems to be the answer, varying with the context, subject characteristics, the techniques used, and the psychological processes which may be outside the participant's awareness.

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

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

Similarly, it is feasible that the use of specific suggestions may interfere with the usual ability of a person to protect themselves. In particular, the alteration of pain perception may, if not done carefully, present the patient with increased risk of failing to respond protectively to a new source of pain, or alterations in the condition being treated.

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

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

What is the evidence that such adverse effects exist? Three types of evidence are

available: clinical anecdotes or case reports; surveys of practitioners; and interviews with participants in clinical, research and entertainment settings.

CLINICAL ACCOUNTS

The Marquis de Puysegar in 1784 expressed concerns about the potential adverse effects of hypnosis when he created 'accidental somnambulism' (Conn, 1981). By the middle of the nineteenth century, frequent concerns were being raised about the use of hypnosis, although in the first instance these related to the manipulation of patients to act against their will or to their seduction (Conn, 1981; Reiter, 1958).

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

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

Meldman (1960) reported a case of 'personality decompensation' following hypnotically based treatment for a flying phobia. Rosen (1960) warned against the ineffective management of abreactions and unspecified psychological sequelae. Meares (1961) expressed concerns about the application of hypnosis with the overly dependent personality type; the pre-psychotic schizophrenic patient; the schizoid personality type; and the depressed patient. He highlighted problems that might arise in dealing with acute panic reactions, abreactions, the incomplete removal of non-therapeutic suggestions, difficulties in terminating 'trance' and symptom substitution. Similarly, Haberman (1987) reported a deterioration in psychological functioning when a non-professional practitioner used hypnosis with a patient with pre-existing psychotic difficulties.

Concerns about the potential for the use of hypnosis to encourage the acting out of suicidal ideas in the depressed patient have been expressed by many clinicians and researchers. Cheek and Le Cron (1968) warned against the use of hypnosis with depressed patients. Similarly, Spiegel and Spiegel (1978), Miller (1979), Burrows (1980), Crasilneck and Hall (1985) and Watkins (1987) expressed the same concerns about the potential for hypnotically based treatments encouraging

patients to act on suicidal ideation. Such views are not universally accepted, particularly by those who use indirect techniques (Gilligan, 1987; Yapko, 1992), but even here there is the caution about the care needed in selecting appropriate techniques.

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

Kleinhauz and Beran (1981) reported on a case where 'stage hypnosis' appeared to precipitate a severe psychological reaction which resulted in threats to the sufferer's physical health and resulted in several hospital admissions. Kleinhauz, Dreyfuss, Beran and Azikri (1984) also reported a case of 'stage hypnosis' being implicated in a participant's psychological distress including anxiety, depression and 'episodic psychotic decompensation' in a subject with pre-existing traumatic experiences. Kleinhauz and Beran (1984) described two further cases where hypnosis appeared to precipitate depression and antisocial behavior respectively. Similarly Allen (1995) reported on an the apparent precipitation of a 'schizophreniform psychosis' following involvement in hypnosis in the setting of 'entertainment'.

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

SURVEYS OF PRACTITIONERS

Averback (1962) surveyed 828 psychiatrists and elicited 210 adverse reactions coincident with the use of hypnosis from the 120 of these practitioners who responded, expressing concerns about the application of hypnosis. The frequent reporting of psychotic decompensation ($N = 119$) was notably higher than in other studies, but may have resulted from the fact that these difficulties would have been referred to a psychiatrist for treatment whereas other difficulties may not require such professional help.

Levitt and Hershman (1962) obtained responses from 866 of the 2500 questionnaires mailed to members of the two principal American Societies of Hypnosis. Of the replies, 301 reported 'unusual reactions' to hypnotic interventions, with anxiety, panic, depression (9.63%); headache, vomiting, dizziness, fainting (4.98%); crying and hysteria (2.99%); and overt psychoses (1.66%) being the most common. This study had many methodological problems and as a consequence, the results are difficult to interpret.

Judd, Burrows and Dennerstein (1985), in their survey of 1086 members of the Australian Society of Hypnosis, reported 88 adverse effects from the 202 responses received. Again the most common of the complications were panic and anxiety (60%); as well as 'over-dependency' (28%); difficulties in terminating trance (28%); and worsened or precipitated psychoses (15%).

SURVEYS OF PARTICIPANTS IN HYPNOSIS RESEARCH

After testing hypnotic susceptibility with the Stanford Hypnotic Clinical Scale (SHSS), Hilgard, Hilgard and Newman (1961) found 8% of their 220 subjects reported transient experiences of headaches, dizziness and confusion. Hilgard's (1974) study of negative effects in 120 subjects, tested for hypnotizability using the SHSS, demonstrated that 16% showed transient negative effects while another 15% experienced negative effects of greater than one hour duration. Crawford, Hilgard and MacDonald (1982) compared the negative effects reported after administration of the Harvard Group Scale of Hypnotic Susceptibility (HGSHS) with those of the Stanford Hypnotic Susceptibility Scale (SHSS), which has a greater number of cognitive items. The use of HGSHS resulted in 5% of the 107 subjects reporting negative experiences with 1% reporting that these lasted for more than one hour. In contrast, the use of the SHSS resulted in 29% reporting negative effects with 12% of these effects lasting over one hour. There was a tendency for more cognitive distortions to be found in the more hypnotizable subjects. Brentar and Lynn (1989) were not able to confirm this association in a study of 240 subjects using the HGSHS.

Echterling and Emmerling (1987) interviewed 105 students who had attended an 'hypnosis stage show'. Of these subjects, 33% reported negative experiences, although they were generally transitory. Misra (1985) reported 16 of 2000 participants who attended a 'stage hypnotist' were referred for negative effects and again these were mostly transitory in nature. Crawford, Hilgard and MacDonald (1992) reported in their study of subjects involved in hypnosis in the 'entertainment' setting, that approximately one-third of those studied reported mild to severe adverse responses although usually of a transient nature. Anxiety and confusion figure prominently in the reported negative effects.

CONCLUSION

In his reviews MacHovec (1986, 1988) reported 86 case examples of adverse effects of hypnosis, with 50% of cases occurring in a clinical setting, 25% in research settings and 25% as a result of stage performances. He generally concluded that the risk of moderate to severe after-effects of hypnosis is 7% in research and clinical samples and 15% in relation to stage performances. His review of the complications of hypnosis began by noting under-reporting of adverse effects of hypnosis in the clinical setting. This may occur because most clinicians, when faced with adverse effects, deal with them utilizing their therapeutic skills and hence the complications are short-lived. In his second review of the complications MacHovec (1988) listed 48 adverse symptom reactions reported by participants who had no such previous problems.

If we consider hypnosis as an altered state of consciousness and a form of

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

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

A review of the clinical and research literature brings us to the following conclusions:

1. There are adverse effects that can arise through the use of hypnosis in clinical and other settings.
2. While most adverse effects are transitory and mildly distressing there is the potential for serious deleterious effects, including psychotic decompensation, depressive and panic reactions, and suicidal acting out.
3. There is no evidence that hypnosis *per se* is the cause of these deleterious effects. Adverse reactions may arise from pre-existing patient vulnerabilities, therapist inexperience in dealing with psychotherapeutic problems, the use of inappropriate suggestions and metaphors, failure to remove unwanted non-therapeutic suggestions, failure to fully reorientate the patient, and failure to debrief the patient adequately.
4. These problems are more likely to arise if the context does not allow them to be adequately addressed (as in stage performances) or if the training and experience of the practitioner is not sufficient for them to deal with the problems as they arise (inadequate training in the areas of hypnosis or psychological functioning).
5. Lay practitioners lacking in the appropriate level of psychological and clinical training are, therefore, more likely to encounter and cause adverse reactions. They are less likely to be able to respond to them therapeutically and ensure the patient's recovery.
6. The practice of hypnosis requires the demonstration of a level of knowledge, skills and supervised training in therapy approaches relevant to the problem being addressed. Most professions require their members to offer treatment only in those fields in which they have appropriate training. The protection of the patient requires this limitation be maintained.
7. Adequate training and accreditation procedures need to be in place to ensure

the patient is not subject to treatment approaches of which the practitioner does not have adequate understanding.

8. The use of hypnosis in contexts that pose greatest dangers ought to be controlled or disallowed for the public protection. Despite the claims to the contrary, there are a significant number of reports of serious sequelae following the use of hypnosis on stage.

The context within which the state is induced may present some problems. If any alteration of cognitive processing interferes with what a person may need to do to maintain their safety, then it may be harmful. Inappropriate associations that facilitate the hypnotic state or failure to return to the usual mode of cognitive functioning may potentially pose a danger, if the person is in a context that needs full attention. These effects are not a consequence of the hypnosis *per se*, but a failure of awareness of cues that may facilitate the hypnotic alteration of attention in some potentially dangerous context. Similarly, failure to return the subject to the usual state of cognitive functioning is not a problem of hypnosis but of its use.

REFERENCES

Allen, D. S. (1995). Schizophreniform psychosis after stage hypnosis. *Br. J. Psychiat.*, **166**, 680.

Averback, A. (1962). Attitudes of psychiatrists to the use of hypnosis. *J. Am. Med. Assoc.*, **180**, 917–921.

Brentar, J. & Lynn, S. J. (1989). Negative effects and hypnosis: A critical examination. *Br. J. Clin. Exp. Hypn.*, **6**, 75–84.

Burrows G. D. (1980). Affective disorders and hypnosis. In G. Burrows & L. Dennerstein (Eds), *Handbook of Hypnosis and Psychosomatic Medicine* (pp. 149–170). Amsterdam: Elsevier/North Holland.

Cheek, D. & Le Cron, L. (1968). *Clinical Hypnotherapy*. New York: Grune & Stratton.

Conn, J. H. (1981). The myth of coercion through hypnosis: A brief communication. *Int. J. Clin. Exp. Hypn.*, **29**, 95–100.

Crasilneck, H. B. & Hall, J. A. (1985). *Clinical Hypnosis: Principles and Applications*. New York: Grune & Stratton.

Crawford, H. J., Hilgard, J. R. & MacDonald, H. (1982). Transient experiences following hypnotic testing and special termination procedures. *Int. J. Clin. Exp. Hypn.*, **30**, 117–126.

Crawford, H. J., Kitner-Triolo, M., Clarke, S. W. et al. (1992) Transient positive and negative experiences accompanying stage hypnosis. *J. Abnorm. Psychol.*, **101**, 663–667.

Eastabrooks, G. H. (1943). *Hypnotism*. London: Dutton.

Echterling, L. G. & Emmerling, D. A. (1987). Impact of stage hypnosis. *Am. J. Clin. Hypn.*, **29**, 149–154.

Gilligan, S. (1987). *Therapeutic Trances: The Cooperation Principle in Ericksonian Hypnosis*. New York: Brunner/Mazel.

Haberman, M. A. (1987). Complications following hypnosis in a psychotic patient with sexual dysfunction treated by a lay hypnotist. *Am. J. Clin. Hypn.*, **29**, 166–170.

Hilgard, J. R. (1974). Sequelae to hypnosis. *Int. J. Clin. Exp. Hypn.*, **22**, 281–298.

Hilgard, J. R., Hilgard, E. R. & Newman, M. R. (1961). Sequelae to hypnotic induction with special reference to earlier chemical anesthesia. *J. Nerv. Ment. Dis.*, **133**, 461–478.
Janet, P. (1925). *Psychological Healing*. New York: Macmillan.
Judd, F. K., Burrows, G. D. & Dennerstein, L. (1985). The dangers of hypnosis: A review. *Aust. J. Clin. Exp. Hypn.*, **13**, 1–15.
Kleinhauz, M. & Beran, B. (1981). Misuses of hypnosis: A medical emergency and its treatment. *Int. J. Clin. Exp. Hypn.*, **29**, 148–161.
Kleinhauz, M. & Beran, B. (1984). Misuse of hypnosis: A factor in psychopathology. *Am. J. Clin. Hypn.*, **26**, 283–290.
Kleinhauz, M., Dreyfuss, D. A., Beran, B. & Azikri, D. (1984). Some after-effects of stage hypnosis: A case study of psychotic manifestations. *Am. J. Clin. Hypn.*, **27**, 219–226.
Kleinhauz, M. & Eli, I. (1987). Potential deleterious effects of hypnosis in the clinical setting. *Am. J. Clin. Hypn.*, **29**, 155–159.
Le Cron, L. (1961) *Techniques of Hypnotherapy.* New York: Julian Press.
Levitt, E. E. & Herschman, C. (1962). The clinical practice of hypnosis in the United States: A preliminary survey. *Int. J. Clin. Exp. Hypn.*, **32**, 55–65.
MacHovec, F. J. (1986). Hypnosis Complications: Prevention and Risk Management. Springfield, IL: Charles C. Thomas.
MacHovec, F. J. (1988). Hypnosis complications, risk factors, and prevention. *Am. J. Clin. Hypn.*, **31**, 40–49.
Marcuse, F. L. (1959). *Hypnosis: Fact and Fiction*. Baltimore: Penguin Books.
Meares, A. (1960). *A System of Medical Hypnosis*. New York: Julian Press.
Meares, A. (1961). An evaluation of the dangers of medical hypnosis. *Am. J. Clin. Hypn.*, **4**, 90–97.
Meldman, M. J. (1960). Personality decompensation after hypnosis symptom suppression. *J. Am. Med. Assoc.*, **173**, 359–364.
Miller, M. M. (1979). *Therapeutic Hypnosis*. New York: Human Sciences Press.
Misra, P. (1985). Psychiatric casualties of stage hypnosis. Paper presented at the 10th International Congress of Hypnosis and Psychosomatic Medicine, Toronto, Canada.
Orne, M. T. (1965). Undesirable effects of hypnosis: The determinants and management. *Int. J. Clin. Exp. Hypn.*, **13**, 226–237.
Page, R. A. & Handley, G. W. (1990). Psychogenic and physiological sequelae to hypnosis: Two case reports. *Am. J. Clin. Hypn.*, **32**, 250–256.
Reiter, P. J. (1958). Antisocial or Criminal Acts and Hypnosis: A Case Study. Springfield, IL: Charles Thomas.
Rosen, H. (1960). Hypnosis: Applications and misapplications. *J. Am. Med. Assoc.*, **172**, 683–687.
Spiegel, H. & Spiegel, D. (1978). Trance and Treatment: Clinical Uses of Hypnosis. New York: Basic Books.
Stanley, R. O. (1994) Adverse effects of hypnosis: Inappropriately or ineptly applied. In B. J. Evans and R.O. Stanley (Eds), *Hypnosis and the Law: Principles and Practice* (pp. 189–197). Melbourne: Australian Society of Hypnosis.
Watkins, J. G. (1987). *Hypnotherapeutic Techniques*. New York: Irvington.
Weitzenhoffer, A. M. (1957). *General Techniques of Hypnotism*. New York: Grune & Stratton.
Williams, G. W. (1953). Difficulties in dehypnotizing. *J. Clin. Exp. Hypn.*, **1**, 3–12.
Wolberg, L. R. (1948). *Medical Hypnosis*. New York: Grune & Stratton.
Yapko, M. D. (1992). *Hypnosis and the Treatment of Depression—Strategies for Change*. New York: Brunner/Mazel.