

# Inadvertent Adverse Consequences of Clinical and Forensic Hypnosis: Minimizing the Risks

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Hypnosis is a psychological intervention tool that can make a gamut of psychological, medical, and dental treatments work more rapidly and effectively. It can also be used profitably with some witnesses, victims, and defendants in forensic and investigative contexts as a data gathering tool. As with any other power tool, its use entails some risks. Since risks cannot be totally avoided, this article examines some ways to minimize the risks of inadvertent adverse or negative consequences as a result of the use of the hypnosis tool. Fundamentals of hypnosis risk management are covered as a foundation for beginners and as a review for experienced practitioners. Various straightforward safeguards that should be heeded by all practitioners are discussed.

**Keywords:** adverse consequences of hypnosis, dangers of hypnosis, ethical practice of hypnosis, hypnosis, hypnosis risks, minimizing risks of hypnosis

Qualified, competently trained, and appropriately licensed health care professionals may make use of hypnosis to facilitate medical, dental, psychological, and related health-promoting treatments and interventions, forensic investigations, and research. As with most things in life, the use of hypnosis has its risks. In any human endeavor, including the treatment of physical, mental, and emotional problems, risks cannot be completely avoided, but constructive efforts may be made to minimize their occurrence and potential to generate unwanted consequences. Risk management entails knowledge, competence, adequate skills, appropriate experience, and a positive attitude.

Hypnosis scholars for the past 150 years have documented multiple cases of immediate and delayed negative effects of hypnosis (Brentar & Lynn, 1988; Ewin, 1989, 2008; Frischholz & Schefflin, 2009; Gruzelier, 2000; Hilgard, 1974; Kluft, 2012; Machovec, 1986, 1988; Weitzenhoffer, 2000). Drawn largely from this author's clinical experience

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and observations, the purpose of this article is to discuss the practice of hypnosis in medical, psychological, and forensic settings and provide recommendations to minimize the risk of occurrence of most common inadvertent adverse consequences, or negative side effects, arising from the use of hypnosis.

A detailed or comprehensive scholarly review of the considerable body of literature on this topic is beyond the scope of this article. The interested reader is referred to Meares (1961), Hilgard (1974), Coe and Ryken (1979), Machovec (1986, 1988), Kleinhauz and Eli (1987), Brentar and Lynn (1988), Schefflin and Shapiro (1989), Page and Handley (1993), Hammond et al. (1995), Brown, Schefflin, and Hammond (1998), Gruzelier (2000), Weitzenhoffer (2000), Hammond, Schefflin, and Vermetten (2001), Hambleton (2002), Ewin (2009), Frischholz and Schefflin (2009), Cardena and Terhune (2009), Schefflin (this issue), and Kluft (2012, this issue-a, this issue-b).

Given the wide disparity in the training of health professionals who employ hypnosis in their particular disciplines (e.g., psychology, medicine, nursing, dentistry, clinical social work, pastoral counseling, substance abuse, etc.), this article will review some of the fundamentals of risk management in clinical and forensic hypnosis in order to serve as a foundation for those new to hypnosis, and as a refresher for more experienced and advanced practitioners. For comprehensive treatments of the fundamentals of using hypnosis safely and effectively, the reader is referred to works by Yapko (1995, 2012), Spiegel and Spiegel (2004), Hambleton (2002), Brown, Schefflin, and Hammond (1998), Kroger and Yapko (2007), Ewin (2009), Lynn and Kirsch (2006), and Zarren and Eimer (2002). In this author's experience, it has proven worthwhile for hypnosis practitioners from time to time to go back to the basics when they encounter new and more complex problems in the applications of hypnosis within their field of expertise. Advanced applications of hypnosis in different health care disciplines as well as in forensic investigations demand that the hypnosis practitioner operate from a solid foundation of basic hypnosis knowledge and skills.

One of the more recent major reviews on adverse effects of experimental, clinical, and stage hypnosis was authored by Gruzelier (2000). Gruzelier, as did Machovec (1986, 1988) before him, examined the problems and documented possible negative side effects when hypnosis is used in any of the three usual settings—experimental testing, clinical practice, and stage (or entertainment) performances. A review of this literature, as well as Kleinhauz and Eli (1987) and Kluft (this issue-a, this issue-b), reveals that hypnosis is not problem-free. As Gruzelier (2000), Hilgard (1974), Kluft (2012), Weitzenhoffer (2000), and others point out, most side effects are trivial and transient, but some are profound, serious, and enduring. In addition, as discussed by Kluft (2012, this issue-a, this issue-b), trance does not always feel good, but many hypnotic subjects who experience serious adverse effects evidence no overt signs of distress. Thus, when using hypnosis with a patient, the clinician should pay close attention to the patient's behavioral manifestations of internal responses, elicit feedback from the patient before, during, and after the trance experience, and competently help him or her manage any negative effects that arise, in

order to minimize the likelihood of immediate and delayed, as well as enduring, negative outcomes.

Even though the induction of trance entails the use of suggestions, it is not the hypnotic trance *state* per se that facilitates therapeutic change and healing, but the effects of the suggestions administered both *before*, *during*, and *after* the hypnosis trance state is induced in the context of the evolving relationship between the clinician and the patient. Zarren and Eimer (2002) talk about the process of “waking state reframing” before formally inducing hypnosis trance in order to build rapport, promote positive expectations by the patient, prepare the patient for experiencing trance, and initiate the therapeutic change process. Along similar lines, the process of socialization for psychotherapy was discussed years ago in a classic article by Martin Orne and Paul Wender (Orne & Wender, 1968).

Once positive expectations have been established (Kirsch, 1994, 2000; Lynn & Kirsch, 2006), the ritual of the trance induction serves to reinforce the patient’s expectations that something different and more powerful than simply talking is occurring (Zarren & Eimer, 2002). This may further the already begun socialization process to the change of behavior, feelings, and beliefs, and heighten the patient’s receptivity to the clinician’s therapeutic suggestions. The administration of trance state suggestions is conceptualized as fixing in place in the patient’s unconscious the changes in feelings and thoughts initiated during the waking state reframing (Zarren & Eimer, 2002).

There are a myriad of techniques for inducing hypnosis trance in another person. What most hypnosis induction techniques have in common is that the hypnotist encourages the subject to follow the hypnotist’s directions, to focus his or her attention, to turn off, or tone down, conscious logic and temporarily suspend his or her disbelief, to imagine as real the things that the hypnotist is saying or suggesting, and to shift into a daydream like experience or manner of thinking (Eimer, 2008; Eimer & Freeman, 1998; Ewin, 2009; Ewin & Eimer, 2006; Graham & Evans, 1977; Spiegel & Spiegel, 2004; Weitzenhoffer, 2000; Yapko, 2012; Zarren & Eimer, 2002). In a clinical setting, in order for a health care provider to be successful in inducing trance in a willing patient, that patient needs to feel safe enough to let things happen. If the patient does not trust or feel comfortable enough with the health care provider, or if the patient remains fearful of the consequences of going into trance, he or she is unlikely to feel safe enough to permit him or herself to be uncritically receptive to the health care provider’s directions and trance induction and trance state suggestions.

The above also translate into the absence of fear on the part of the patient that the hypnosis practitioner might make the patient behave in a way or feel something that is not safe enough for the patient. Equally as important, the patient must have confidence in the hypnosis practitioner’s skills, ability, good intentions, and professionalism (Ewin & Eimer, 2006; Zarren & Eimer, 2002). Ultimately, the practice of clinical and forensic hypnosis is a series of confidence-based transactions. If both the hypnosis practitioner and the patient do not have confidence in what is happening and going to happen, then there will likely be no truly effective therapeutic transaction (Hunter & Eimer, 2012).

In any case, there is always a risk that any of the trance induction directions and trance state suggestions could activate distressing associations, thoughts, feelings, and memories in the patient such that the trance experience inadvertently turns into an unpleasant daydream, or worse, a nightmare, if memories of trauma are activated. In any clinical or forensic situation, this is where the competence of the hypnosis practitioner is necessary for helping the patient/client get through the experience without being traumatized or re-traumatized. What the competent clinician does to accomplish this goal should depend on his or her primary health care discipline (e.g., psychology, medicine, dentistry, nursing), the purpose of the session/visit (e.g., psychotherapy, hypnotherapy, hypnosis by a dentist for dental work, hypnosis in a medical setting for preparation for surgery), and the health care provider's judgment about that individual case in that moment in time. The clinician may decide that it is necessary to facilitate the patient's processing of the emerging material or that he or she must help the patient shut it down.

In clinical or forensic settings, negative consequences are more likely to occur when hypnosis is used inappropriately or by inadequately trained health care providers who do not employ good common sense, good clinical judgment, and proper safeguards (Brentar & Lynn, 1988; Hambleton, 2002; Kleinhauz & Eli, 1987; Machovec, 1986, 1988; Yapko, 2012). The remainder of this article will discuss important considerations for employing hypnosis responsibly and ethically in clinical and forensic situations so that the risks of inadvertent adverse consequences are minimized.

Although this article will concentrate on the conduct of clinical and forensic hypnosis sessions, a few words are in order about the potential dangers when the motives or beliefs of the hypnotist are themselves questionable.

### Ensure the Welfare of the Patient

Some therapists choose to use hypnosis for purely selfish purposes, such as patient seduction, or to satisfy their own narcissistic needs to be recognized as powerful and important. The dangers of eroticism and hypnosis date back at least to Mesmer (Schefflin, 2011). Approximately 30 appellate cases in the United States have involved claims of sexual conduct performed under hypnotic compulsion. Media reports frequently appear on this topic (Bowling, 2010). When therapists give primacy to the satisfaction of their own narcissistic needs over ensuring and enhancing the welfare of their patients/clients, they create an unacceptable likelihood of doing harm to their patients/clients.

### Recognize the Limitations of Hypnosis

An additional danger occurs when hypnotists and clinicians who use hypnosis uncritically consider hypnosis a cure for anything and use it for every condition a patient/client presents. Or, the hypnotist may believe that everything he or she does is "hypnotic,"

and that hypnosis has magical curative possibilities. Hypnosis is a powerful mode of communication, and must be respected as such and used with caution and care. In fact, Freud became so afraid of its power that he chose to abandon it entirely (Chertok & de Saussure, 1979). The actuality is that hypnosis is a tool that is not appropriate for every condition. Hypnosis clinicians who act as though they believe that the solution to every problem is hypnosis reduce every clinical problem to terms exemplified by Abraham Maslow (1966, p. 15) when he stated, "I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail."

### Use Hypnosis in Suitable and Appropriate Settings

It is inappropriate and unethical for health professionals to use hypnosis in social situations other than clearly defined clinical, educational (training), forensic, and research settings with the hypnotic subject's documented informed consent. As stipulated in the Ethical Code of Conduct of the American Society of Clinical Hypnosis (2012), "ASCH members do not use or endorse or assist in the use of hypnosis for entertainment purposes." Also, these guidelines stipulate that: "When members do appear in public forums, such as on television or some other electronic format, they take care to ensure that any demonstration of hypnosis is done in such a way as to prevent or minimize risk to unknown audience participants . . . For example, when a videotape demonstration is shown on television, the member takes steps to ensure that the complete audio portion of the induction and deepening phases are muted" (see <http://asch.net/LinkClick.aspx?fileticket=UQ%2b4P4VoecE%3d&tabid=117>).

The most probable likelihood of the occurrence of adverse consequences with hypnosis occurs when hypnosis is used with people for whom hypnosis is usually contraindicated (see below), and when a context is created that activates in the hypnotic subject negative affect states, behaviors, and physical reactions such as panic, performance anxiety, shame, embarrassment, paranoia, feelings of loss of control, damaging histrionic or exhibitionist tendencies, uncontrolled dissociation or dangerous hysterical and physiological reactions (Ewin, 2008; Frischholz & Schefflin, 2009; Heap, 1995; Meares, 1961).

During and after stage hypnosis shows, people in the audience as well as volunteer subjects on stage can be adversely affected, as there is no control over who is observing in the audience and meager evaluation of selected volunteers. Some spectators and volunteer subjects may have hysterical reactions, while others may experience the emergence of uncomfortable affect states, the intrusion of traumatic memories, or dissociative reactions. If during the exhibition, the subject volunteered sensitive personal information, or, in response to the hypnotist's suggestions, acted in ego-dystonic ways, this could lead to panic states and marked shame and embarrassment associated with unresolved inner conflicts brought up during the experience (Kleinhaus, Dreyfuss, Beran, Goldberg, & Azikiri, 1979).

There have been multiple reports of stage hypnosis causing markedly negative reactions, both psychologically and physically, immediate and delayed, and short-term and long-term, in volunteer subjects (Ewin, 2008; Frischholz & Schefflin, 2009; Gruzelier, 2000; Heap, 1995). For all of the above reasons, licensed health professionals who practice hypnosis and professional hypnosis societies such as the American Society of Clinical Hypnosis and the Society for Clinical and Experimental Hypnosis do not endorse stage hypnosis or the use of hypnosis for entertainment purposes.

### Identify When People Should Not Be Hypnotized

Responsible hypnosis practitioners do not attempt to hypnotize anyone in settings where it is unlikely that appropriate follow-up can be provided or arranged if immediately necessary. For example, in hypnosis workshop settings, workshop leaders should be vigilant and remain available to provide any necessary assistance should a workshop participant experience a problematic reaction during or after hypnosis practice sessions or demonstrations (Kluft, 2012, this issue-a, this issue-b). In workshop settings, workshop leaders should obtain an appropriate level of informed consent from workshop participants before the participants engage in hypnosis practice exercises or observe hypnosis demonstrations. Workshop participants should be given the choice of whether or not to participate as a subject in hypnosis exercises. They should also be fore-warned before viewing any videotaped hypnosis demonstrations that contain significantly negative affect laden material.

In any clinical setting, the clinician should perform a context appropriate intake evaluation, before obtaining the necessary informed consent from the patient/client. Likewise, in hypnosis workshop settings, trainees should be taught to always obtain their training partner's verbal consent to be the subject before beginning any hypnosis exercise in which their partner is to be the subject.

In this author's opinion, there are certain categories of persons who should not be hypnotized, except under specific circumstances by clinicians who are competent to work with these individuals (MacHovec, 1986; Meares, 1961; Yapko, 2012; Zarren & Eimer, 2002). These categories include people who are markedly paranoid, actively psychotic, schizophrenic, severely borderline, markedly dissociative, and persons with certain unstable medical conditions (Wain, Amen, & Oetgen, 1984) that could be acutely aggravated by negative emotional states. Using hypnosis with such individuals carries a significant risk of their experiencing an acute or delayed psychological decompensation, or a problematic medical event. The specific circumstances in which hypnosis might be indicated for such individuals, with appropriate medical clearance and informed consent, would include in the context of a trusting working therapeutic alliance in the psychotherapy office, in a safe setting in a medical or psychiatric hospital, or for legitimate research or forensic purposes.

In the hands of clinicians competent to treat higher risk categories of patients; for example, psychotic and dissociative patients, the hypnosis tool can often significantly enhance the therapy when it is appropriately, competently, and sensitively integrated into the treatment (Hodge, 1988; Kluff, 1982, 1985; Watkins & Watkins, 1997).

In this author's opinion, people who are acutely intoxicated, inebriated, high, or under the influence of consciousness altering drugs, should almost never be hypnotized in any setting because the hypnotic context could further lower their inhibitions from engaging in inappropriate, dangerous, high risk or destructive behavior. Furthermore, given their diminished mental acuity and clouded mental clarity, hypnosis is not likely to be useful. For hypnosis to be most useful as a treatment or forensic tool, the subject must be in a receptive learning state, able to comprehend instructions, focus and sustain attention, and communicate with the hypnosis practitioner.

Given the above, it is also this author's opinion that it is usually ill advised to employ hypnosis with people who do not have enough intellectual capacity to understand what hypnosis is, what it is not, and its limitations (Hunter, 2010; Yapko, 2012). The most likely benign result is that such a subject will simply not be able to sustain attention enough to enter a hypnotic state. However, a possible adverse consequence is that such a subject will misunderstand the hypnotist's suggestions and act-out unsafely.

Based on this author's clinical experience, child, adolescent, and adult patients/clients with learning disabilities, impulse control problems, attention deficit disorder, and mild mental retardation may sometimes benefit from direct suggestion in hypnosis and self-hypnosis training for addressing goals such as relaxation, anxiety management, attention control, and impulse control (Kohen & Olness, 2011). However, hypnosis should not be used in these cases with children, adolescents, or adults who are dependent on a guardian without the informed consent of a competent and legitimate guardian.

There are also many adult and elderly patients who can benefit from hypnosis for pain management, treatment of depression, and anxiety management whose ability to give informed consent is compromised by virtue of physical weakness, mild dementia, or oral or written expressive language deficits. This author has worked with many such patients over the years in medical inpatient and nursing home settings who fall into this category. In such cases, informed consent should be obtained from a competent and legitimate guardian.

In this author's opinion, it is important to proceed with caution before employing hypnosis with people who have clearly identified sociopathic personality traits, or who have been diagnosed as having an antisocial personality disorder, unless an appropriate evaluation leads the clinician to conclude that hypnosis for a specific therapeutic or forensic purpose is indicated. The use of hypnosis may give some so-inclined individuals an acceptable excuse for acting out inappropriately. Therefore, a proper evaluation in an appropriate setting is a must.

In most cases, hypnosis practitioners should not use hypnosis with patients or clients that they do not feel competent to treat otherwise. Hypnosis is not a panacea. However,

there are certain conditions for which hypnosis appears to be the best treatment option available when all other forms of treatment have failed to yield favorable enough outcomes. For example, tinnitus is a notoriously difficult condition to treat effectively. “In many cases, there is no specific treatment for tinnitus. It may simply go away on its own, or it may be a permanent disability that the patient will have to ‘live with’” (see [www.medicinenet.com/tinnitus/page2.htm](http://www.medicinenet.com/tinnitus/page2.htm)). Hypnosis can be a valuable treatment tool for some patients with tinnitus, for which there are few if any efficacious alternative treatments available (Marlowe, 1973; Mason & Rogerson, 1995).

In most cases, the efficacy of the hypnosis treatment tool depends upon, among other things, the competent hypnosis practitioner’s assessment of the patient’s experiential resources and inner strengths (Frederick & McNeal, 1998), the practitioner’s identification and utilization of those experiential resources and strengths that are relevant to realizing the goals of treatment (medical, dental, or psychological), and the clinician’s delivery of suggestions, including ego strengthening suggestions (Heap & Aravind, 2002) that facilitate the patient’s recovery or acquisition and appropriate utilization of those relevant experiential resources and strengths.

### Clarify That Hypnosis Is Not a Lie Detector or Truth Serum

Hypnosis is not a lie detector. In most clinical and forensic settings, including mental health and psychotherapy settings, it is inappropriate to employ hypnosis as a tool to detect deception or lying, notwithstanding Martin Orne’s hypnotic research manipulations designed to detect deception (Waid & Orne, 1981). People who are in trance can lie as well as withhold information (Cheek, 1993; Hammond et al., 1995; Schefflin & Shapiro, 1989; Yapko, 2012). Occasionally, this author’s office receives phone calls from individuals who want hypnosis for themselves or for a paramour so that each can find out whether the other may have been unfaithful (i.e., “cheating”). In this author’s opinion, it is, of course, never appropriate to agree to use hypnosis for this purpose. Such individuals need competent couples counseling, individual therapy in some cases, and in some cases a private investigator.

Over the years, this author has also been contacted by people who wanted hypnosis to help them find out if they were sexually abused as children. These types of callers need education. They need to be helped to understand that hypnosis can be used as a tool to “refresh” memories, but not as a tool for conclusively uncovering the truth of what really happened in the past (Brown, Schefflin, & Hammond, 1998; Hammond et al., 1995). This is because human memory does not operate like a tape or video recorder. Memory is a reconstructive cognitive and affective process. Episodic and narrative memories contain reconstructions. The nature of those reconstructions is influenced by the person’s cognitive and emotional state at the time the data was acquired and the memory was encoded, as well as by how the original experience was organized perceptually and cognitively initially and in subsequent recollections (Brown, Schefflin, & Hammond, 1998).

It is a mistake for hypnosis practitioners to validate clients' beliefs that hypnosis can help them retrieve from their memory only truthful and accurate information about what really happened (Geiselman & Machlovitz, 1987). Hypnosis can facilitate and in some cases enhance recall, but the accuracy of the recalled material can only be determined by independent corroboration and verification (Schefflin & Shapiro, 1989). A clinician utilizing hypnosis to facilitate a patient's or client's recall should explain that no memory assisting technique, including hypnosis, can guarantee the truth of what is recalled. The consequences of failing to provide this cautionary instruction could be that false accusations may be made against innocent persons, and the patient's or client's suffering may be intensified (Brown, Schefflin, & Hammond, 1998). The value of any information that has been hypnotically refreshed is best determined by investigative validation to confirm that the memory accessed was accurate (Hibler & Schefflin, this issue; Wester & Hammond, 2011).

### Employ Appropriate Safeguards When Using Hypnosis to Refresh Memory

In this author's experience, one of the biggest traps that hypnosis practitioners who are health care professionals can fall into when conducting hypnoanalysis and hypnotic regression sessions is inappropriate leading of the patient/client (Hunter & Eimer, 2012). This occurs when the health care professional forms a preconceived opinion regarding the cause/s of the patient's problems before hypnotizing the patient, and then proceeds to use hypnotic regression techniques to validate that opinion. Inappropriate leading is a major cause of what has been called "false memory syndrome" (Brown, Schefflin, & Hammond, 1998; Schefflin & Shapiro, 1989).

Leading suggestions are not a problem specific to hypnosis. In any communication, leading questions or statements can distort memory (Brown, Schefflin, & Hammond, 1998). This can lead the patient/client to believe false perceptions to be facts. Inappropriate leading can be avoided by asking open ended questions and through the appropriate use of ideomotor signals in hypnosis (Ewin & Eimer, 2006). It can also be avoided when the mental health professional conducts a good hypnosis pre-talk in which the limitations of hypnosis as a memory refreshment tool and the necessity of neutrality on the part of the therapist are discussed (Hunter & Eimer, 2012; Page & Handley, 1993).

When a person truly is in hypnotic trance, that person is suggestible. Therefore, during a hypnotic regression session, well intended therapist comments verbalized to express empathy (e.g., "that little boy must be feeling angry," "daddy is scaring you," "little girl wants to run away") or as an expression of preconceived opinions (e.g., "your daddy needs you because mommy isn't giving daddy any attention"), can be accepted uncritically by the patient and become imprinted suggestions. Such inappropriate leading comments can inadvertently result in the creation of false memories in that the patient acquires beliefs that something happened, that he or she felt a certain way, or that something happened for a particular reason, when in fact, such beliefs are not factually

grounded. On the other hand, poorly worded questions and suggestions may also obscure and/or suppress the patient's communication of mistreatments that actually did occur.

While the outcomes of inappropriate leading and poorly worded questions and suggestions can be innocuous, they can also imprint suggestions and obscure or suppress communications that can result in disruptions of family homeostasis and the ruination of lives. In forensic and investigative hypnosis, inappropriate leading during hypnotic interviews can contaminate memories and result in a witness's testimony being ruled inadmissible in court (Schefflin, this issue; Schefflin & Shapiro, 1989; Brown, Schefflin, & Hammond, 1998; Wester & Hammond, 2011). In clinical hypnosis in mental health settings, the obfuscation or suppression of the patient's communications can undermine the patient's trust and faith in the therapist and undermine the integrity of the therapeutic working relationship.

In forensic and investigative contexts, hypnosis should only be used where there is a likelihood of enhancing recall and the possibility of independent corroboration of the recalled material (Hibler & Schefflin, this issue; Schefflin & Shapiro, 1989; Wester & Hamond, 2011). Forensic hypnosis is an investigative tool for obtaining data that provides leads for subsequently finding out the truth and solving the case. However, it must not include leading the patient to come up with specific memories in either the pre-hypnotic or hypnotic interviews. That is why standardized procedures that include videotaping all contacts with the subject should be followed in forensic and investigative hypnosis so that the real time contents of these interviews can be reviewed (Hibler & Schefflin, this issue; Schefflin, this issue; Wester & Hammond, 2011). It is important for the forensic hypnosis practitioner to know the laws governing the use of hypnosis and the admissibility of the hypnotized client's future testimony in court in the state in which he or she is working a case (Hibler & Schefflin, this issue).

If accepted standardized procedures are not followed, the improper handling of the hypnosis session in forensic and investigative settings can undermine the integrity and accuracy of the expert witness's evaluative efforts (Brown, Schefflin, & Hammond, 1998; Schefflin, this issue; Schefflin & Shapiro, 1989). Good data and valuable testimony can be ruled inadmissible as evidence, thus creating roadblocks to the exoneration of the innocent and the apprehension and punishment of the guilty (Schefflin, this issue). For specific guidelines on how and how not to set up and conduct a forensic hypnosis interview, see the articles by Schefflin (this issue) and Hibler and Schefflin (this issue), as well Wester and Hammond (2011), and *The Guidelines on Hypnosis and Memory* developed by the American Society of Clinical Hypnosis (Hammond et al., 1995).

### Conduct an Adequate Intake Evaluation Before Employing Hypnosis

In every health care field, each intervention and series of interventions should have a well conceptualized rationale. In the psychotherapy field, it is necessary to perform

an appropriate initial evaluation of the patient in order to formulate an adequate case conceptualization. The latter forms the basis for a treatment plan that is individualized to the patient. The case conceptualization should be updated as more data is obtained in follow up contacts with the patient (Alladin, 2007, 2008; Beck, 2011; Kuyken, Padesky, & Dudley, 2011; Zarren & Eimer, 2002). The intake evaluation and case conceptualization should form the basis for how hypnosis is employed as a tool in the treatment (Zarren & Eimer, 2002). Failure to perform an adequate intake evaluation can result in the clinician missing important details and employing a “cookie cutter” approach to treatment. This is when hypnosis induction and suggestion scripts are verbalized rigidly based largely on a patient’s presenting symptoms and complaints while ignoring individual differences.

In this author’s opinion, some of the important individual differences in patients that should be evaluated, depending on the clinical setting, and when appropriate and feasible to take into account in formulating a treatment plan, include: patient expectations and goals, background history, any history of trauma, level of intelligence, education, verbal sophistication and communication skills, cultural differences and experiences, vocational background, level of suggestibility and hypnotizability, previous experiences with hypnosis and ideas about what hypnosis is, ability to focus and sustain attention, personality styles, psychiatric and medical status, anxiety levels, mood states, level of motivation, cooperation and investment in the treatment process, the client’s potentially useful unique skills and experiences, and psychodynamic and interpersonal roots of the patient’s problems (Eimer, 1996; Ewin & Eimer, 2006; Yapko, 2012; Zarren & Eimer, 2002).

In this author’s opinion, the negative consequences of using a cookie cutter approach that does not take into account individual differences can include the clinician missing important details which can result in failure to achieve good rapport and a positive working alliance, the promotion of a negative transference, failure to capitalize on the patient’s positive expectations, failure to capitalize on the client’s unique useful experiences, failure to formulate an appropriate and effective treatment strategy and recurrently update it, failure to provide hypnotic suggestions that fit the patient’s current needs, and the delivery of suggestions that are unfitting or offensive. All of the above can result in failure to help the patient get better.

### Obtain Informed Consent

It is essential to obtain informed consent from patients to perform evaluations and conduct treatment before proceeding. This is no less the case with hypnosis as an evaluation and treatment tool (Frischholz, 2001; Hammond et al., 2001; Lynn, 2001). Four elements of informed consent are (a) evaluating the competency of the patient, (b) disclosure of relevant material information to the patient that is context appropriate, (c) making sure

the patient understands this disclosure, and (d) obtaining the patient's voluntary consent (Wall & Marcus, 2012).

Obtaining informed consent for hypnosis is a process (Frischholz, 2001; Hammond et al., 1995, 2001) and the way in which informed consent is obtained should be a function of the nature of the clinical, forensic, or research setting and how hypnosis is to be employed in that context:

1. Before employing hypnosis with a patient a health care provider must determine the type of hypnotic intervention that would be appropriate given the clinician's evaluation of the patient's level of cognitive competency. Then, the clinician must determine whether the patient is cognitively competent enough to give informed consent. If the patient is not, then, if hypnosis is still indicated, the clinician should obtain informed consent from the patient's legal guardian.
2. Next, a health care provider must communicate the relevant material information to the patient or patient's guardian in terms and on a level that the patient or guardian can understand. The clinician's presentation should include an appropriate disclosure of the risks and benefits of the proposed hypnosis in *that* particular setting given *how* hypnosis is to be employed and *for what* purpose.
3. A health care provider should make sure that the patient or guardian does in fact comprehend the information (and the risks versus the benefits) just disclosed.
4. A health care provider should obtain the patient's or guardian's informed consent, at least verbally, and this should be documented in the clinician's notes and the patient's chart. Depending on the context it may or may not be advisable to also obtain a signed written informed consent form. There is a wide discrepancy among the criteria for obtaining adequate informed consent in different jurisdictions (Frischholz, 2001; Hammond et al., 1995, 2001).

Failure to obtain the appropriate form of informed consent for hypnosis can result in unpleasant surprises for both the patient and the clinician (Coe & Ryken, 1979; Frischholz, 2001; Lynn, 2001), as well as formal complaints filed against the professional at his or her state regulatory board. Patients may be reluctant to be hypnotized for a variety of reasons. These include fear of losing control, lack of trust, paranoia, religious beliefs, previous bad experiences, things they have been told by others, or the desire to simply talk with the therapist. These are blocks to ethical and effective uses of hypnosis that should never be breached. They must be addressed and worked through before using hypnosis.

Failure to obtain informed consent, especially in a clinical setting, can additionally result in a gamut of unfavorable consequences of varying severity (Coe & Ryken, 1979; Frischholz, 2001; Lynn, 2001), ranging from loss of the patient's trust and confidence (recall that hypnosis is a series of confidence-based transactions), patient resentment, not being able to induce hypnosis, and not meeting the patient's needs, to the patient

feeling victimized, increasing the patient's anxiety level, patient confusion, unexpected abreactions, re-traumatization, and precipitation of a dissociative episode.

As previously explained, properly obtaining informed consent for hypnosis is a process that involves more than simply having a patient read and sign an informed consent form. Anxiety and fear about hypnosis and discomfort with the hypnosis practitioner are likely to prevent the patient from entering hypnosis or going deep enough to do effective work. Before doing hypnosis with a patient for the first time, it is therefore essential that the clinician conduct an appropriate pre-hypnosis talk, or hypnosis pre-talk, in order to orient the client to hypnosis. This talk should include correcting misconceptions about what hypnosis is, defining hypnosis, delineating the limitations of hypnosis, educating the patient about what will be expected of him or her, encouraging positive but realistic expectations, and addressing and alleviating any fears that the client has about being hypnotized based on misinformation or previous bad experiences.

In this author's opinion, it is best to avoid following scripts when giving a hypnosis pre-talk. The clinician should individualize the hypnosis pre-talk to the patient and convey the information in his or her own words (Hunter & Eimer, 2012). This author typically covers the following areas in his pre-hypnosis talks in mental health and medical settings. These can be modified as needed depending on the hypnosis practitioner's primary health care discipline and the clinical setting:

1. The three-part model of the mind: conscious, subconscious, and unconscious.
2. The fact that hypnosis is a natural altered state phenomenon, and that we all enter and exit hypnoidal and hypnotic states naturally every day.
3. The fact that, in health care, hypnosis is a state of focused attention and heightened suggestibility to beneficial therapeutic suggestions, and when appropriate, a special state of communication and rapport in which the patient becomes more in tune with his or her innermost feelings and more capable of using his or her inner resources and strengths to accomplish realistic agreed upon emotional and behavioral goals.
4. The fact that clinical or therapeutic hypnosis is different than stage hypnosis.
5. The fact that the choice to enter hypnosis and to become suggestible (i.e., receptive to suggestions for change) lies within the patient.
6. The fact that no one can be made to do something they find objectionable *solely* through the use of hypnosis, and that hypnosis is not a truth serum.
7. The fact that all hypnosis is self-hypnosis, the therapist is just a facilitator; and that anyone who wants to be hypnotized can experience hypnosis as long as they can focus and sustain their attention, and as long as they are not afraid and are partners in the hypnotherapy process. The patient is told that he or she can resist if he or she wants to, but then the therapist cannot be of help.
8. That, as used clinically, hypnosis is a special learning state of relaxed effortless attention, increased suggestibility and controlled daydreaming and imagination. That anyone who can pay attention, follow instructions, and daydream can

experience hypnosis, and that the client should simply think and imagine the things that the therapist suggests as long as these things are acceptable. That it is the therapist's job to analyze, not the patient's, and that the one thing that is most likely to interfere with the patient entering a good trance is if the patient tries too hard as opposed to just letting things happen (Ewin, 2009). In addition, if the therapist says anything that does not "fit" or feel right, the client can either ignore it, or change it in his or her own mind to what he or she needs to hear.

9. If a clinician uses touch as part of his or her hypnotherapy techniques, it is important that the clinician explain to the patient where he or she would touch the patient during the hypnosis and hypnotherapy process (e.g., hand, arm, shoulder, head, and forehead) and for what reason. In this author's opinion, it is essential for the clinician to obtain the patient's permission to touch wherever he or she intends to touch the patient *before* actually touching the patient during the induction of hypnosis and subsequently. If the patient indicates that he or she does not want to be touched, or if touch is contra-indicated, the clinician had better not touch. (Note: it is important for mental health providers to be familiar with state licensure laws regarding touching patients.)

After conducting the intake evaluation, doing the hypnosis pre-talk, and assessing the patient's readiness to enter hypnosis, *before* doing hypnosis with the patient for the first time, the clinician should ask the patient for permission to do hypnosis. Depending on the context, written or simply verbal (and subsequently documented) informed consent should be obtained.

In this author's opinion, every time the clinician intends to do hypnosis with the patient, he or she should obtain the patient's explicit agreement by asking something such as, "Would you like to do hypnosis with me now?" A congruent "Yes" is what the clinician is looking for in order to proceed on solid ground. After hypnosis has been used the first time, it is seldom necessary to give the same hypnosis pre-talk again, although selected points may require re-emphasis at times. It is also seldom necessary to obtain written informed consent after it has been obtained the first time.

### Formulate and Implement an Appropriate Treatment Plan

Hypnosis is conceptualized as a tool for enhancing the treatment of the patient whether that treatment is medical, dental, or psychological (Zarren & Eimer, 2002). The induction of trance in and of itself is not a treatment. It is a means to an end. The treatment is how the trance state is used and the hypnotic treatment strategies employed (Spiegel & Spiegel, 2004). Thus, when using hypnosis, as when conducting any therapeutic treatment, it is important to formulate an appropriate treatment strategy in every clinical case.

The clinician's case conceptualization forms the backbone for the treatment plan, and the treatment plan should guide the treatment, but also be updated based on new information that comes to light and the patient's changing status.

If a health care professional is competent and licensed to treat patients with a range of presenting problems within his or her primary discipline, then, with an appropriate level of education and training in hypnosis, that clinician should be able to assess when hypnosis as an assessment, therapy, or medical tool would be indicated and when it would not be. In this author's experience, complications can arise when clinicians use hypnosis when it is not indicated and when it does not fit into the treatment plan. In such cases, hypnosis in and of itself is not the problem. It is the clinician's mistreatment or mismanagement of the patient.

For example, if a patient is opposed to the use of hypnosis, hypnosis should, of course, not be used. If a patient is not hypnotizable or responsive to hypnosis, continuing to use hypnosis wastes time and discourages the non-responsive patient. In this author's experience, it is typically not a good idea to do hypnosis when the clinician and patient should be talking. Some patients with some problems need talk therapy, education, guidance, coaching, or advice. The issue of whether or not hypnosis ought to be included in the treatment plan should be decided based on the case formulation and client's/patient's consent.

It may go without saying, that just because a patient requests hypnosis does not mean that the clinician should use hypnosis. In some cases, the patient's motive for wanting the hypnosis might be questionable. In other cases, if hypnosis is used, there should be conversations and assessments both before and after performing any hypnotic interventions. Following the hypnosis portion of a session, it is also important to debrief with the patient. It is also inappropriate to use deception in order to conduct hypnosis with patients who are opposed to hypnosis, by couching hypnosis as something else, such as relaxation therapy or guided imagery. Clinical and forensic hypnosis should be non-deceptive (Kirsch, 1994).

All of the above can be avoided by formulating, following and working from an appropriate treatment plan.

### **Make Sure the Patient Has Had an Adequate Medical Work Up Before Using Hypnosis for Pain Control**

Hypnosis is an empirically validated, evidenced-based treatment tool for managing physical pain; both its sensory and emotional components (Eimer & Freeman, 1998; Jensen, 2011; Patterson, 2010). Hypnotic treatment strategies for pain either suppress, alter, diminish, or mask the perception of pain, or address underlying emotional and psychological factors maintaining the pain (Eimer, 2000, 2008; Eimer & Freeman, 1998). It should be well known that if the pain is signaling that there is an acute or progressive

disease or injury that requires medical attention, and this signal is ignored, masked, or suppressed, the health outcomes could be devastating. One of the primary concerns in all medical hypnosis is inappropriately blocking the perception of body stimuli within the patient indicating that a problem is present (Eimer, 2008; Eimer & Freeman, 1998; Wain et al., 1984). Therefore, it is well advised to employ hypnotic treatment strategies with pain only after a patient has been adequately worked up medically, appropriately medically evaluated, and diagnosed.

Licensed mental health professionals are qualified to treat the emotional overlay and behavioral and experiential concomitants of pain. Physicians and dentists are qualified to treat the physical aspects. Hypnosis can facilitate the treatment of all of these aspects (Eimer, 2008; Eimer & Freeman, 1998).

There is also another potential inadvertent negative consequence that can result from using hypnosis improperly with pain patients. It stems from the fact that hypnosis can sometimes fix ideas and suggestions in place in a patient's mind. If a clinician using hypnosis inadvertently reinforces, or fails to remove, iatrogenic negative suggestions inadvertently given to the patient by other well-meaning health professionals, negative expectations and further dysfunctional behaviors can then become the patient's reality. These ideas and suggestions then guide behavior and can become self-fulfilling prophecies. Thus, we endeavor to imprint positive suggestions that are associated with positive expectations and adaptive physiology and behavior (Kirsch, 2000).

### Carefully Select Words

While a detailed or complete discussion is far beyond the scope of this article, a general statement is in order. Hypnosis is a language based transaction (Ewin, 2009; Zarren & Eimer, 2002; Lankton & Lankton, 1983/2008). In everyday conversation, the words and labels people use to name and describe their experiences influence their expectations, feelings, behaviors, and how they deal with and act as a result of those experiences (Watzlawick, 1993). In therapeutic and forensic settings, words and labels may be even more influential. And the power of words in terms of their influence on a subject's experience is nowhere more significant than when hypnosis is employed. As pointed out by Ewin (2009), "We are treating people with words, so the dictionary and thesaurus are our pharmacopoeias. What we say, what we omit, and how we say it matters very much. Even without hypnosis this is ancient knowledge" (p. 1).

For example, talking about decreasing pain has different connotations than does talking about relieving discomfort or increasing comfort. For example, suggesting to a patient that "you will not feel as much pain," is likely to be heard by the patient's subconscious inner mind as "you will feel much pain." Suggestions, to be accepted by the patient, should be delivered in a form in which the patient can understand and relate. Thus, it is important to speak the patient's experiential language (Lankton & Lankton, 1983/2008). If the clinician employs language to which the patient cannot

relate, this may lead to failure to achieve rapport and failure to elicit the patient's cooperation and collaboration in the therapy process (O'Hanlon, 2009; Zarren & Eimer, 2002).

### Take Into Account the Role of Psychodynamic and Interpersonal Factors in Creating and Maintaining Symptoms

A man with a history of alcoholism who had been abstinent for six years went to see a health care professional using hypnosis to help him stop smoking. After his two sessions of direct suggestion in hypnosis (DSIH) with the hypnotherapist, he stopped smoking, but he began drinking again. Similarly, another woman went to see a health care professional using hypnosis to help to stop smoking. After one session of DSIH, she stopped smoking. However, she began to overeat and gained 30 pounds in nine months. Another woman with a history of panic disorder saw a psychologist for help with her disabling panic attacks. The psychologist used DSIH and cognitive-behavior therapy (CBT) to help her learn "coping skills." The patient learned positive self talk, affirmations, progressive muscle relaxation, and controlled diaphragmatic breathing. After several months of treatment, she became severely depressed and needed to be hospitalized after attempting suicide.

In all three previous cases, the clinicians focused exclusively on symptom suppression or alleviation with DSIH and/or CBT without addressing the psychodynamic and interpersonal roots of the problem. In all three cases, this resulted in different, substitute, symptoms. Stedman's (2005) defines *symptom substitution* as "an unconscious psychological process by which a repressed impulse is indirectly manifested through a particular symptom, anxiety, compulsion, depression, hallucination, obsession." Obviously, the unconscious psychological processes underlying a patient's symptoms need to be addressed in order to facilitate favorable long-term results. The inadvertent negative consequences of exclusively focusing on symptom suppression can often be "symptom substitution."

As discussed throughout Milton Erickson's writings (Havens, 2005), a symptom is an attempted solution. Thus, in many cases, the clinician needs to uncover the patient's fixed ideas and inner (intrapsychic) and interpersonal conflicts to find out what underlying problems the presenting symptoms are attempting to solve. When a patient violates a fixed idea, conscious or unconscious, even if the idea is hurtful, it often creates anxiety (Ewin, 2009; Ewin & Eimer, 2006). This is why it is frequently not sufficient to rely exclusively on DSIH solely directed to help a patient obtain relief from bothersome symptoms without uncovering the patient's underlying fixed idea. Once a critical dystonic idea has been identified through techniques such as CBT, insight therapy, or hypnoanalysis, or so on, it can be replaced (i.e., reframed) with a syntonic idea. This requires that the competently trained mental health provider evaluate the psychodynamic and interpersonal roots of the problem and treat the causes of the problem with hypnosis

and good psychotherapy (Ewin & Eimer, 2006; Hunter & Eimer, 2012; Zarren & Eimer, 2002).

### Adequately Pace the Patient/Subject

Pacing as referred to here means achieving and maintaining good rapport with the patient or subject as the patient continues to change moods or states (Lankton, 1980/2003). As mentioned, hypnosis is a series of confidence-based transactions, such that if there is no confidence, there is no transaction. Good rapport is a necessary ingredient.

Zarren and Eimer (2002) write about the “conscious use of the therapist’s self,” which means staying aware of and effectively managing one’s own “counter-transference” toward the patient. Counter-transference reactions arise from the clinician’s unconscious. They explain that the “conscious use of self” requires the clinician to make an ongoing conscious effort to be aware of his or her spontaneous and reflexive (unconscious or preconscious) emotional reactions to the patient’s presentation and behavior. Zarren and Eimer (2002) point out that, by maintaining an ongoing awareness of his or her own preconscious and, possibly, to the unconscious generated responses to the patient, the clinician will be better equipped to respond to the patient in a neutral manner. This can make the clinician better able to avoid interpreting the patient’s provocative behaviors as personal slights which would distract him or her from continuing to work toward the best interests of the patient.

It is well known that it is necessary for the clinician to be aware of the risk of counter-transference issues and to monitor him or herself with an open mindedness toward the possibility of finding some pattern of reaction that is problematic. This is necessary in order for the clinician to remain neutral and avoid becoming evolved emotionally with the patient’s issues. A neutral stance is most likely to facilitate the clinician’s empathizing and “resonating” (Watkins, 1978) with the patient so that he or she can capture and match the idioms, predicates, and adjectives the patient uses to describe his or her experience. Cultural sensitivity is also important in this regard.

In the psychotherapy context, Watkins (1978) and Watkins and Watkins (1997) specifically wrote about “therapeutic resonance” and the special empathic qualities of the therapist that made “resonating” with the patient possible. Ewin (2009) points out that good “hypnosis is an empathetic involvement with another, and as we interact with our patients/clients, we evolve in our tone of voice, choice of words, what we emphasize, and our timing” (p. 38).

The Ericksonian hypnosis literature emphasizes the importance of achieving rapport through matching the patient’s verbal and non-verbal behaviors, adequately pacing the patient, and then leading the patient in a therapeutically hypnotic direction in the service of the therapy (Havens, 2005; Lankton & Lankton, 1983/2008). Inadequate pacing of the patient/client can lead to failure to achieve and maintain rapport, failure to induce a good trance, and rejection of the clinician’s suggestions.

### Add an Endpoint to Suggestions When Appropriate

Suggestions for sensory alterations such as analgesia or anesthesia should often be administered with clear endpoints. For example, Ewin (2009) explains that “analgesia should last only ‘until it is healed’ or post-op as long as you need it” (p. 60). For patients suffering lingering difficulties, as a result of this type of mistake, a simple suggestion such as “It was a good idea at the time, but now that it’s healed you no longer need it” can often remove the problem.

### Make Sure the Patient/Client Is Adequately De-Hypnotized and Re-Alerted

In this issue, Kluft (this issue-a, this issue-b) writes about the problem of failure to adequately de-hypnotize a hypnotic subject. He provides many examples of how this can happen in both educational/training and clinical settings, the inadvertent negative consequences, and he provides multiple solutions for preventing it from happening in the first place and repairing the damage after the fact. Of course, this can also happen in forensic settings about which Kluft did not deal in his articles. When a subject is not adequately de-hypnotized, he or she is not adequately alert. This can result in the subject feeling tired, foggy, clouded, disoriented, dissociated, violated, anxious, paranoid, overly emotional, and remaining undesirably suggestible and vulnerable.

Essentially, incomplete de-hypnotization boils down to failure to employ thorough enough and appropriately directive re-alerting techniques (Kluft, 2012, this issue-a, this issue-b), failure to adequately assess that the patient is fully alert and feels okay, and neglecting to remove undesirable suggestions given during trance (Ewin, 2009). It is often a mistake to be too permissive in terms of leaving it to the hypnotized subject to “emerge” from hypnosis when the subject is ready, or when the subject’s unconscious mind has accomplished such and such.

This author has made it his practice to routinely check in with his patients to assess their level of alertness and mental clarity after re-alerting them from trance. This author has found it useful to have the freshly re-alerted patient close his or her eyes again so that he can guide the patient in emerging and re-alerting again and this time more thoroughly. There is an additional upside to doing this. Typically, after the second re-alerting, patients report that they feel much more alert, awake, sound in mind, sound in body, and in control of their feelings, and that they feel really good. This repeated re-alerting up is like the reverse of the Vogt fractionation method for inducing a deeper level of hypnosis (Kroger & Yapko, 2008).

Another useful method is to be sure to employ an all-encompassing “wipe out” re-alerting suggestion that directly tells the patient that when he or she opens his or her eyes, he or she will be mentally clear, have no lingering unwanted motor or sensory aberrations, and be stable emotionally (Eimer & Ewin, 2006; Ewin, 2009).

## Conclusion

Hypnosis is a psychological intervention tool that can make a gamut of psychological, medical, and dental treatments work more rapidly and effectively (Zarren & Eimer, 2002). It can also be used profitably with some witnesses, victims, and defendants in forensic and investigative contexts as a data gathering tool (Wester & Hammond, 2011). As with any other tool, its use entails some risks. Since risks cannot be totally avoided, this article has examined some ways to minimize the risks of inadvertent adverse or negative consequences as a result of the use of the hypnosis tool. Given that good hypnosis involves an empathic involvement with the patient/client, the hypnosis practitioner should pay attention to how the relationship with and treatment of the patient/client is conducted and managed.

Inadvertent negative consequences of hypnosis vary in their severity. Among the least negative consequences are that the patient simply does not respond to the hypnosis or feels alienated. However, serious negative consequences can include inadvertently setting the patient up for needless emotional suffering, traumatizing or re-traumatizing the patient, precipitating the patient's psychological decompensation, leading the psychotherapy or other clinical treatment astray, failing to provide medically necessary treatment, or ruining a client's chances of realizing justice in a forensic legal context. Such problems seldom result from the use of hypnosis per se, but rather from how, when, and where hypnosis, is employed.

Gruzelier (2000) has written that:

the responsible contemporary scientific attitude should be to acknowledge that untoward effects of hypnosis do exist, to educate all practitioners about them, to put safeguards in place to minimize their likelihood, and to consider the mechanisms that underlie them in order to facilitate the adoption of safeguards. Recognition is handicapped by the fact that unwanted aftereffects are discomfiting for the field of clinical hypnosis and its interface with an increasingly litigious world. . . . Education about unwanted effects and safeguards should be a requirement for all practitioners. (p. 188)

It is in the spirit of his wise observation that this article has been written.

In conclusion, the risks of inadvertent negative consequences are minimized when the adequately trained, competent, and ethical hypnosis practitioner does the following:

1. Ensures the welfare of the patient,
2. Recognizes the limitations of hypnosis,
3. Employs hypnosis in a suitable and appropriate setting,
4. Employs hypnosis with people who are appropriate to hypnotize as determined by an appropriate intake evaluation,
5. Employs hypnosis with patients he or she is competent to treat,
6. Conducts an adequate intake evaluation,
7. Obtains adequate informed consent from the patient or subject,
8. Gives a good hypnosis pre-talk before employing hypnosis,
9. Formulates an adequate case conceptualization and an appropriate treatment plan,
10. Implements the treatment plan appropriately based on the case conceptualization,

11. Appropriately integrates the hypnosis tool into the treatment plan,
12. Employs appropriate safeguards when hypnosis is used to refresh memory,
13. Makes sure there has been an adequate medical work up before hypnosis is employed for pain control or in the treatment of other medical conditions,
14. Carefully selects his or her words,
15. Adequately paces the patient or subject,
16. Focuses both on symptom alleviation and the psychodynamic and interpersonal roots of the problem,
17. Adds an endpoint to suggestions when appropriate, and
18. Adequately de-hypnotizes and re-alerts the patient/subject.

Knowledge is power if it is used appropriately. Hypnosis can be a powerful tool that can facilitate clinical treatment in a variety of health care disciplines as well as clinical and forensic assessment. There is a wide disparity in the training of health professionals who employ hypnosis in their particular disciplines (e.g., psychology, medicine, nursing, dentistry, clinical social work, pastoral counseling, substance abuse, etc.), and a wide variety of appropriate settings in which hypnosis is used. Therefore, it is sometimes useful to go back to basics to review the fundamentals of hypnosis and hypnosis risk management that are applicable to most settings in which the hypnosis tool is employed.

The use of hypnosis, as does the use of any tool, entails some risks. It is the professional's responsibility to manage the risks so that their likelihood of realization is minimized to an acceptably low level. In addition, if the hypnosis tool is used improperly, the treatment process can be harmed or derailed, and this can compound the risks to the patient and the patient's emotional distress. This article was written to help beginning health care providers who employ hypnosis to use hypnosis wisely and well.

In this author's experience, it is also worthwhile from time to time to go back to the basics as the health care practitioner encounters new and more complex problems in his or her field of expertise. Advanced applications of hypnosis in different health care disciplines and in forensic investigations demand that the hypnosis practitioner have a solid foundation of basic hypnosis knowledge and skills.

The fundamentals of risk management in clinical and forensic hypnosis have been reviewed in this article in order to serve as a foundation for those new to hypnosis and as a refresher for more experienced and advanced practitioners. Risk management is facilitated when advanced applications of hypnosis are built on a solid foundation.

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