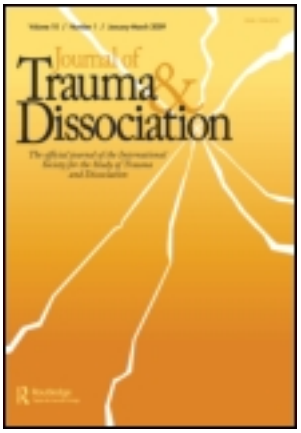

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The Same Old Elephant ...

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EDITORIAL

The Same Old Elephant . . .

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> We shall not cease from exploration, and the end of all our exploring will be to arrive where we started and know the place for the first time.—T. S. Eliot (*Little Gidding,* 1991, p. 210)

Efforts persist within the dissociative disorders field in general and within many of its current models, theories, and therapeutic approaches to bypass, dismiss, marginalize, or otherwise dissociate hypnosis from their mainstream concerns. These endeavors provide an ongoing source of delicious irony, painful distress, and intellectual astonishment to researchers and clinicians whose experience, expertise, and explorations encompass both areas of study. For such individuals, three salient facts together suffice to establish hypnosis and hypnotizability as foundational concerns in the study and treatment of dissociation and the dissociative disorders: (a) Hypnotizability, a genetically mediated capacity (e.g., Raz, Fan, & Posner, 2006), is high in most dissociative disorder populations (e.g., Frischholz, Lipman, Braun, & Sachs, 1992). (b) Hypnotic phenomena occur commonly in most dissociative populations and play a significant role in their psychopathology (Braun, 1983). (c) Dissociation is regarded as a central component of hypnosis (Spiegel & Spiegel, 2004). Hypnosis or trance may be induced by another person; may be self-induced; or may occur spontaneously, without conscious intention, in response to many forms of internal experience and external events. Only the first is under the influence of the researcher or clinician. High hypnotizability is commonly encountered

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in traumatized individuals whose conditions become most chronic and prolonged (Spiegel, Hunt, & Dondershine, 1988; Stutman & Bliss, 1985).

Of additional importance to the clinical encounter with dissociative patients is a phenomenon little noted outside the field of hypnosis: Highly hypnotizable individuals are vulnerable to slipping into alert trances in which, with eyes wide open, they manifest many of the qualities of the more formally and traditionally hypnotized subject. That is, they may demonstrate (among other phenomena) a decline in their generalized reality orientation (Shor, 1959), a reduction in the alertness and activity of their critical intellect, a toleration of mutually incompatible perceptions without reacting to their incompatibility (trance logic; Orne, 1962), the intensification of affect, rapid mobilization of transference phenomena, and an increased responsiveness to suggestions. These well-known phenomena, often associated with problematic moments in the treatment of traumatized and dissociative disorder patients, are not generally appreciated as being mediated at least in part by hypnosis. It stands to reason that the more clearly this possibility is understood, the more prepared the clinician is to appreciate and address these difficult matters and to contain or channel their hypnotic components. These concerns provide powerful incentives to study hypnosis in order to maximize therapeutic effectiveness with traumatized and dissociative disorder patients.

From this perspective no approach to dissociation and the dissociative disorders can be comprehensive without taking hypnotizability and its associated phenomena into account. The many connections between dissociation and hypnosis conceptually and phenomenologically and the often constructive responses of dissociative patients to therapeutic hypnosis led many pioneers in our field to give hypnosis a place of importance in understanding and addressing dissociative psychopathology.

The relationship between hypnosis and the treatment of dissociative disorders began with the pioneering work of Despine (1840; Ellenberger, 1970; McKeown & Fine, 2008). Despine was the first to appreciate that the dissociative disorders were a "magnetic" (we would say "hypnotic") pathology, the first to observe a significant cohort of dissociative patients, the first to apply hypnotic techniques in the treatment of these patients, and the first to bring about the successful integration of a patient with dissociative identity disorder (DID). Despine was followed by many European contributors, preeminently Janet (1889/1973), who knew of Despine's work and also used hypnosis to understand and treat dissociative psychopathology. This heritage continues into the modern era and includes the theoretical contributions of (among others) Beahrs (1982), Bliss (1986), Braun (1983), Frischholz et al. (1992), and John and Helen Watkins (1997), who explored the interface of hypnotic and dissociative phenomenology; and, in clinical matters, those who explored the role of hypnosis in the treatment of dissociative disorders, including (among others) Allison (1974), Bowers et al. (1971), Braun (1988a,

1988b), Caul (1984), Fine (1991, 1993, in press), Kluft (1982, 1994), Newton (see Bowers et al., 1971), Phillips and Frederick (1995), and Watkins and Watkins (1997).

A review of the proceedings and workshop offerings of the international conferences of the International Society for the Study of Trauma and Dissociation (formerly the International Society for the Study of Dissociation and originally the International Society for the Study of Multiple Personality & Dissociation) from 1984 to the present demonstrates that interest in hypnosis as a treatment modality was vigorous in its early history. However, over time the prominence of hypnosis declined. As that sequence of events often described as "the memory wars" unfolded in the 1990s, militant efforts to link the use of hypnosis with memory distortions and false memories had a chilling effect on the willingness of the Society and many of its members to promote or to be identified with the use of hypnosis as a treatment modality. This undermined the willingness of many individuals to use or to learn to use hypnosis in general and/or to apply hypnosis to the treatment of trauma or dissociative disorders in particular.

For students of both irony and the history of science, the rapid capitulation to those who attacked the use of hypnosis by the vast majority of those in the dissociative disorders field is worthy of exploration. The work of Loftus (1993) and allied colleagues was lionized. Notwithstanding these contributions' shortcomings and limited applicability to the therapeutic situation, they were enlisted energetically into efforts to discredit hypnosis. A scholarly review of memory and hypnosis by McConkey (1992) had concluded that memory distortions attributed to hypnosis were accounted for by the hypnotizability of the subjects and the suggestiveness of the inquiries but not by the induction of hypnosis, which did not contribute to memory distortion. That is, given the high hypnotizability of dissociative patients (excluding a cohort of those who suffer from depersonalization disorder), which is not subject to meaningful alteration, and the lack of impact upon memory of inducing hypnosis, scholarly concern should have focused on styles of inquiry and the expectations and pressures imposed before and during questioning instead of attacking hypnosis. That being said, hypnosis may have an impact on whether the subject concretizes his or her responses (i.e., tends to hold on to what has emerged in hypnosis as if it is actually the case with a tenacity that may make it difficult to pursue alternative paths of understanding, a crucial matter in forensic contexts) and should be used with caution on that account.

It is particularly fortunate that hypnosis itself is not the great distorter of memory it was represented to be, because, as noted previously, given the hypnotic talent of most dissociative individuals, hypnosis inevitably will play an important role in their lives and treatments whether or not efforts are made to induce it. The only way to treat most dissociative disorder patients without acknowledging the inevitability of hypnosis is to redefine

hypnosis to be limited to heterohypnosis, avoid doing formal inductions, and declare that no hypnosis has occurred. Many clinicians who are aware that such rationalizations are inaccurate nonetheless affirm, defensively and/or for political reasons, that they practice without using hypnosis. They have to plot a careful course around the elephant in the living room while convincing themselves and others that no pachyderm is present and that their circuitous paths of reasoning are direct and without detours. They see but refuse to see or acknowledge the same old elephant. Zerubavel (2007) advanced a similar argument in the literature on sociology.

Because hypnosis has a venerable history as a beneficial modality in the treatment of dissociative disorders, and because most of the major therapeutic successes reported in the early modern era of studying the dissociative disorders have involved the use of hypnosis, it is instructive to wonder what fate befell the classic hypnosis-derived techniques associated with those successes as the dissociative disorders field progressively marginalized and dismissed hypnosis itself. Again, as we inspect the living room of the dissociative disorders field, largely cleansed of any acknowledgements of the presence of any visible large gray vegetarian mammals bearing tusks and a trunk, we make a curious discovery. In their haste to banish hypnosis as they understood it, those who led the charge had not appreciated that they were banishing only one of many constructs of hypnosis, the one in which the subject sits with eyes closed in what appears to be an altered state. The eyes-open construct of waking or alert hypnosis was overlooked in this purge. If we look carefully, we note that the same techniques and suggestions developed for use with heterohypnosis continued to be applied to highly hypnotizable subjects without either party acknowledging that many if not most of these interventions are hypnotic in a hypnotizable subject despite the lack of a formal induction. Several schools of therapy have adopted and incorporated many major hypnotic techniques, changed their names slightly (if at all), and proclaimed them, usually without acknowledgement of their origins, as techniques developed within and/or embraced by their own paradigms. Furthermore, several new approaches focused on the body–mind interface, always the home field of hypnosis, use "new" techniques that give old hands in the world of hypnosis a chuckle because generations of hypnosis practitioners have relied upon them, and Bennett Braun (1988a, 1988b) applied many of them to the dissociative disorders in his publications about the Behavior, Affect, Sensation, Knowledge (BASK) model. No matter how hard many have tried to drive it away or to generate a negative hallucination that appears to make it vanish, the same old elephant continues to graze in the living room, for all we know chuckling in pachydermal amusement at the intricate intellectual dances that attempt to circumnavigate the denied but all too present bulk of the very beast that has been wished away but is still there.

When students of the dissociative disorders debate hypnosis, two interesting perspectives are often voiced by those who try to pretend that the elephant is not really there. The first calls to mind Dorothy's arrival at the Emerald City in the magical land of Oz (Baum, 1900). Before being allowed to enter the Emerald City, she was obliged to put on emerald-colored glasses. No emerald glasses, no Emerald City! A scientific version of the Wizard of Oz's clever ploy creates a paradigm that either does not acknowledge or declines to privilege hypnosis. Carrying on guided by a model of the world that does not include hypnosis, it becomes thereby banished from the realm of scientific discourse (Kuhn, 1996; Zerubavel, 2007).

In his obituary of Charcot, Freud (1893) shared the following vignette:

> Charcot, indeed, never tired of defending the rights of purely clinical work, which consists in seeing and ordering things, against the encroachments of theoretical medicine. On one occasion there was a small group of us, all students from abroad, who, brought up on German academic physiology, were trying his patience with our doubts about his clinical innovations. "But that can't be true," one of us objected, "it contradicts the Young-Helmholtz theory." He did not reply "So much the worse for the theory, clinical facts come first" or words to that effect; but he did say something which made a great impression on us: "*La théorie*, *c'est bon, mais ça n'empêche pas d'exister*." (p. 12). These words are translated, "Theory is good; but it doesn't prevent things from existing." (p. 12)

Many elephant-excluding formulations are current in the dissociative disorders field these days, but the moment one takes off one's paradigm-colored glasses, it is not difficult to discern the looming presence of the same old elephant, placid and undisturbed.

From time to time I encounter publications that omit mention of or misstate the results of my articles on treatment outcome (Kluft, 1984, 1986, 1993). Ultimately almost 90% of the treatment-adherent patients have achieved and sustained integration. I used hypnosis in my work. I think that a factor in my success was my willingness to acknowledge and work with the same old elephant, and my patients benefited from my collaboration with the venerable pachyderm. However, when those articles are either not cited or are mis-cited, a rather powerful (albeit anecdotal) argument for the importance of hypnosis in the treatment of the dissociative disorders is dismissed.

Perhaps one of the most interesting ways to approach the intricately interwoven relationships between hypnosis and the dissociative disorders is to step away from these issues, which at times have become embattled, and comment briefly upon an exciting emergent area that does not concern bringing hypnosis into the treatment of the dissociative disorders. Instead, it regards how hypnotic strategies originally developed for the treatment of

DID are being incorporated into efforts to promote improvements in the safety of hypnosis training and practice. This initiative, the result of several years of research, has been implemented slowly in the workshops of the Society for Clinical and Experimental Hypnosis, and the underlying thinking and supporting research is only now reaching publication. In fact, the articles to which I refer (Howard, in press; Frischholz, 2011, in press; Kluft, 2011a, 2012, in press-a, in press-b) are all still in press as I write this editorial.

Hypnosis experienced in the context of research and clinical practice and in both stage hypnosis and hypnosis done by amateurs is associated with the occurrence of unwanted adverse effects in a minority of subjects (e.g., Gruzelier, 2000; MacHovec, 1986; Orne, 1965). However, reports of mishaps during the use hypnosis in the training of health and mental health professionals are virtually absent from the literature. I (Kluft, 2012) encountered three instances of serious adverse consequences of hypnosis in hypnosis workshop participants (2001–2004) and discovered that the literature had not addressed such situations. I initiated a series of studies to explore both these phenomena and their startling absence from the literature.

I also began to make presentations on workshop safety based on these three cases and others encountered subsequently. Over a 5-year period 24 colleagues who were experienced and expert practitioners of hypnosis came forward to share previously unrevealed adverse workshop experiences, and three colleagues came directly from bad workshop experiences at professional association meetings we were attending to request my help. In all, I was able to interview 30 colleagues who had suffered adverse experiences in hypnosis workshops. I also did participant observer research in hypnosis training workshops for several years, observing more than 70 hypnotic exercises in basic workshops and 40 exercises in advanced workshops. I also surveyed 25 colleagues, experienced and expert in hypnosis, who had never experienced adverse effects of hypnosis.

What I found is that 93% of those who had suffered adverse effects had evaded detection by workshop faculty. Only 2 of the 30 had shown signs that had drawn the attention of the faculty and their peers; they also had reported their distress. Moreover, 100% of those who suffered adverse effects had not been completely realerted after their hypnotic experience. One became symptomatic during a first hypnosis experience, but 29 or 97% got into difficulty after one experience after another built upon the hypnotic residua of incomplete realerting from previous exercises. Deliberately inducing trance repeatedly is a deepening technique, Vogt's fractionation method (see Kroger & Yapko, 2008). Unrecognized cycles of trance induction and incomplete dehypnosis may have created inadvertent deepening via unintended fractionation. I also found that most workshop efforts to realert subjects had been permissive in form; all 30 subjects had experienced incomplete realerting with such approaches. Most incomplete permissive

realertings observed during my research seemed without unwanted consequences, but that all 30 casualties had occurred subsequent to one or more unsuccessful permissive realertings was a powerful and striking discovery.

Why had most of these adverse effects remained undetected, though some had led to powerful abreactions, decompensations, and long periods of dysphoria? I discovered that these colleagues uniformly (a) had tremendous ego strength, (b) had been socialized during their professional training to contain their emotions and modeled themselves after respected senior colleagues and mentors who contained themselves, and (c) were ashamed of their difficulties and preferred suffering in privacy to what they anticipated would be public humiliation. This yielded the following formulation: Strength + Socialization + Shame = Silence.

These findings led me to develop several suggestions to reduce the likelihood of workshop casualties (Kluft, in press-a, in press-b). Reduced to their essence, these suggestions promote vigorous efforts to bring about realerting and to identify problems in realerting. To reduce the vulnerability of both workshop participants and patients, they recommend screening for trance residua and emphasize using directive methods of realerting, which appear to be more easily understood and successful with subjects new or relatively new to hypnosis.

A promising instrument still being researched and as yet unvalidated is the Howard Alertness Scale, developed by Hedy Howard (2008). Howard began to collaborate with me on matters of workshop safety and rose to the challenge of measuring the emergence of hypnotic subjects from trance (i.e., realerting). Howard appreciated that the usual approach of asking subjects to estimate whether they remained in hypnosis was conceptually flawed. First, hypnosis continues to elude a consensual definition, making operationalizing its presence or absence problematic. Second, because such efforts implicitly involve trying to prove a negative, they slide rapidly into a familiar morass—"the absence of evidence is not evidence of absence." She reasoned that if the goal of taking someone out of trance is to reestablish that person's pre-trance alertness, a more reasonable approach might be to compare baseline pre-trance alertness with alertness measured after an attempt has been made to realert the subject from the trance. Benchmarked pre-hypnotic indicators of alertness from the Howard Alertness Scale are matched against the same indicators after attempted realerting. This appears to make it possible to ascertain whether, or to what extent, suggestions made to realert a subject from trance have actually accomplished their goal. In one pilot study I (Kluft, 2011b, 2012) found that as many as 85% of a cohort of high hypnotizables who initially affirmed that they were completely realerted actually were continuing to experience residual hypnotic phenomena. This is a very unsettling finding in view of the importance of achieving effective dehypnosis and protecting the subject from leaving the office with his or her cognition and coping impaired.

This may sound at least vaguely familiar to dissociative disorder therapists. The importance of bringing the DID patient's treatment session to a satisfactory ending has been a major concern of hypnosis-savvy DID therapists. Kluft and Fine both wrote at length about the importance of concluding sessions with the patient reoriented and restored to a personality configuration that was consistent with safe and reality-oriented functioning (Fine, 1991, 1993, in press; Fine & Berkowitz, 2001; Kluft, 1982, 1994, 1996, 2000). Implicit in these efforts is the importance of bringing to an end any dysfunctional residual trance state or trance phenomena.

Both Howard and Kluft were experienced in treating dissociative disorder patients. They appreciated that both hypnosis workshop participants and patients who undergo therapeutic hypnosis might benefit from interventions analogous to those that dissociative disorder therapists use to ground and reorient DID/DDNOS (dissociative disorder not otherwise specified) patients. At session's end, many DID/DDNOS patients remain in an altered state or executive control resides in an alter ill suited to function successfully in daily life. In DID treatment, interventions to reorient and restabilize DID patients, to remove them from such altered states, and to restructure their personality systems are commonplace. Three major categories of these approaches involve grounding, reorienting, and reconfiguration (Fine, in press; Kluft, 1982, 1994). Efforts are made to resituate patients to being present in their bodies, to being oriented to the present time and place, and to becoming aware of the context of major contemporary events and relationships in their lives. Furthermore, it is important to restore or develop mental configurations able to accurately assess and respond to contemporary realities, obligations, and circumstances.

Changes suggested for use in hypnosis workshops and clinical practice are designed to address any residual trance elements noted as deviations from the Howard Alertness Scale's baseline benchmarked indicators. They suggest that persistent trance residua should be addressed until the workshop participant or patient is truly restored to his or her baseline benchmarked alertness (Howard, in press; Kluft, in press-a, in press-b).

Pilot efforts to introduce such interventions were made at a Basic Hypnosis course presented at the 2009 annual meeting of the International Society for the Study of Trauma and Dissociation. They were very successful in identifying those whose realerting had been incomplete and those who were becoming distressed. In all cases early identification led to interventions that restabilized the participant (Kluft, 2010). The fields of hypnosis and dissociation have tremendous potential to be of significant assistance to each other. Neither field can fulfill its full promise and potential without being informed and enriched by the other.

Both George Bernard Shaw and Milton Erickson are credited with the following words: "If you cannot get rid of the family skeleton, you may as well make it dance" (Shaw, 1931, p. xxiv). I could not find these words

in the works of Milton Erickson, but George Bernard Shaw penned these words in his embarrassingly stumbling autobiographical work, *Immaturity*. Shaw wrote this as a young man, but it was not published until he was 75 years of age, and then only in a private edition. Regardless of its source, this advice is good. I would like to expand the wisdom of Shaw or Erickson or both to encompass as well the lot of those elephants who dwell in our living rooms or elsewhere within our domiciles (and I want to include any stray mammoths and mastodons that we might encounter, however improbable that might be). Therefore, reformulating this advice of uncertain parentage to the needs and purposes of the moment, we might say, "If you have an elephant in your living room, at least you can let it teach you to dance." Those of us who work with dissociative patients are engaging in a form of treatment, the foundations of which are rooted deeply in the hypnotic efforts of major contributors to our knowledge, from Despine and Janet to Jack and Helen Watkins and myriad others. We serve ourselves and our patients best if we master the use of hypnosis and understand the meaning of its rich intellectual and therapeutic heritage for our clinical work and our research. We also best serve our patients and ourselves and promote our scientific understanding if we encourage the researchers among us to add measures of hypnotizability and a diverse range of hypnosis-related phenomena (such as suggestibility) to the batteries of tests that they administer to their subjects.

The study and treatment of dissociative disorders began and was sustained into the modern era by the efforts of those in the field of hypnosis. This valuable and venerable connection has been disregarded too long in the aftermath of the memory wars. The landmark contributions of Brown (1995) and Brown, Scheflin, and Hammond (1998) should have stopped the dissociative disorders community's retreat from hypnosis in its tracks. A return to this amazing source of knowledge and wisdom and its reintegration into the dissociative disorders field is long overdue.

T.S. Eliot (1991) reminds us how often we must turn about to actually appreciate, for the first time, what we have left behind. The dissociative disorders field is overdue for a return to the study of hypnosis, perhaps to "know the place for the first time." It is timely to allow the venerable pachyderm to be seen, recognized, appreciated, and perhaps allowed to teach us some wisdom and some moves we never would have been able to acquire and master without the formidable contributions of that same old elephant.

REFERENCES

Allison, R. B. (1974). A new treatment approach for multiple personalities. *American Journal of Clinical Hypnosis*, *17*, 15–32.

Baum, L. F. (1900). *The wonderful wizard of Oz*. Chicago, IL: Hill.

Beahrs, J. (1982). *Unity and multiplicity*. New York, NY: Brunner/Mazel.

Bliss, E. (1986). *Multiple personality, allied disorders and hypnosis*. New York, NY: Oxford University Press.

Bowers, M. K., Brecher-Marer, S., Newton, B. W., Piotrowski, Z., Spyer, T. C., Taylor, W. S., & Watkins, J. (1971). Therapy of multiple personality. *International Journal of Clinical and Experimental Hypnosis*, *19*, 57–65.

Braun, B. G. (1983). Psychophysiological phenomena in multiple personality and hypnosis. *American Journal of Clinical Hypnosis*, *26*, 124–137.

Braun, B. G. (1988a). The BASK model of dissociation. *Dissociation*, *1*(1), 4–23.

Braun, B. G. (1988b). The BASK model of dissociation: Part II—Treatment. *Dissociation*, 1(2), 16–23.

Brown, D. (1995). Pseudomemories, the standard of science, and the standard of care in trauma treatment. *American Journal of Clinical Hypnosis*, *31*, 1–24.

Brown, D., Scheflin, A., & Hammond, D. C. (1998). *Memory, trauma treatment, and the law*. New York, NY: Norton.

Caul, D. (1984). Groups and videotape techniques for multiple personality disorder. *Psychiatric Annals*, *14*, 43–50.

Despine, A. C.-H. (1840). *De L'Emploi du magnétisme animal et des eaux minerales dans le traitement des maladies nerveuses, suivi d'une observation très curieuse de guérison de névropathie* [A study of the uses of animal magnetism in the treatment of disorders of the nervous system followed by a case of a highly unusual cure of neuropathy]. Paris, France: Germer Baillière.

Eliot, T. S. (1991). Little gidding. In T. S. Eliot (Ed.), *Collected poems 1909–1962*: *T.S. Eliot* (pp. 200–210). New York, NY: Harcourt Brace.

Ellenberger, H. (1970). *The discovery of the unconscious*. New York, NY: Basic Books.

Fine, C. G. (1991). Treatment stabilization and crisis prevention: Pacing the therapy of multiple personality disorder patients. *Psychiatric Clinics of North America*, *14*, 661–675.

Fine, C. G. (1993). A tactical integrationalist perspective on the treatment of multiple personality disorder. In R. P. Kluft & C. G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 135–153). Washington, DC: American Psychiatric Press.

Fine, C. G. (in press). Cognitive hypnotherapy of the dissociative disorders. *American Journal of Clinical Hypnosis*.

Fine, C. G., & Berkowitz, S. A. (2001). The wreathing protocol: The imbrication of hypnosis and EMDR in the treatment of dissociative identity disorder and other dissociative responses. *American Journal of Clinical Hypnosis*, *43*, 275–290.

Freud, S. (1893). Charcot. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 3, pp. 7–23). London, England: Hogarth.

Frischholz, E. J. (2011, March). *Professional hypnosis workshops: Potential liabilities?* Paper presented at the annual meeting of the American Society of Clinical Hypnosis, Las Vegas, NV.

Frischholz, E. J. (in press). Professional hypnosis workshops: Understanding and preventing potential liabilities. *American Journal of Clinical Hypnosis*.

Frischholz, E., Lipman, L., Braun, B., & Sachs, R. (1992). Psychopathology, hypnotizability, and dissociation. *American Journal of Psychiatry*, *149*, 1521–1525.

Gruzelier, J. (2000). Unwanted effects of hypnosis: A review of the evidence and its implications. *Contemporary Hypnosis*, *17*, 163–193.

Howard, H. A. (2008). The Howard Alertness Scale. *Focus*, *50*, 5–6.

Howard, H. A. (in press). Clinical applications of the Howard Alertness Scale. *American Journal of Hypnosis*.

Janet, P. (1973). *L'Automatisme psychologique* [Psychological automatisms]. Paris, France: Societe Pierre Janet: Paris. (Original work published 1889)

Kluft, R. P. (1982). Varieties of hypnotic interventions in the treatment of multiple personality. *American Journal of Clinical Hypnosis*, *24*, 230–240.

Kluft, R. P. (1984). Treatment of multiple personality. *Psychiatric Clinics of North America*, *7*, 9–29.

Kluft, R. P. (1986). Personality unification in multiple personality disorder. In B. G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 29–60). Washington, DC: American Psychiatric Press.

Kluft, R. P. (1993). Treatment of dissociative disorder patients: An overview of discoveries, successes, and failures. *Dissociation*, *6*, 87–101.

Kluft, R. P. (1994). Applications of hypnotic interventions. *Hypnos*, *21*, 205–223.

Kluft, R. P. (1996). Treating the traumatic memories of patients with dissociative identity disorder. *American Journal of Psychiatry*, *153*, 103–110.

Kluft, R. P. (2000). The psychoanalytic psychotherapy of dissociative identity disorder in the context of trauma therapy. *Psychoanalytic Inquiry*, *20*, 259–286.

Kluft, R. P. (2010, November). *Determining the determinants of a hypnosis workshop casualty: An exegesis and a reflection*. Paper presented at the annual meeting of the Society for Clinical and Experimental Hypnosis, Boston, MA.

Kluft, R. P. (2011a). Reversing rogue trances: Realerting the bewitched, bothered, and bewildered, and recognizing the befuddled. *Newsletter of the American Society of Clinical Hypnosis*, Fall, 3–6.

Kluft, R. P. (2011b, March). *Toward enhancing workshop safety: A continuing odyssey*. Paper presented at the annual meeting of the American Society of Clinical Hypnosis, Las Vegas, NV.

Kluft, R. P. (2012). Issues in the detection of those suffering adverse effects in hypnosis training workshops. *American Journal of Clinical Hypnosis, 54*, 213–232.

Kluft, R. P. (in press-a). Enhancing workshop safety: Learning from colleagues' adverse experiences (Part I—Structure/content). *American Journal of Clinical Hypnosis*.

Kluft, R. P. (in press-b). Enhancing workshop safety: Learning from colleagues' adverse experiences (Part II—Structure/policy). *American Journal of Clinical Hypnosis*.

Kroger, W., & Yapko, M. (2008). *Clinical and experimental hypnosis* (Rev. 2nd ed., pp. 82–83). Philadelphia, PA: Lippincott Williams & Wilkins.

Kuhn, T. (1996). *The structure of scientific revolutions* (3rd ed.). Chicago, IL: University of Chicago Press.

Loftus, E. F. (1993). The reality of repressed memories. *American Psychologist*, *48*, 518–537.

MacHovec, F. (1986). *Hypnosis complications: Prevention and risk management*. Springfield, IL: Thomas Books.

McConkey, K. M. (1992). The effects of hypnotic procedures on remembering: The experimental findings and their implications for forensic hypnosis. In E. Fromm & M. R. Nash (Eds.), *Contemporary hypnosis research* (pp. 405–426). New York, NY: Guilford Press.

McKeown, J. M., & Fine, C. G. (Eds. & Trans.). (2008). *Despine and the evolution of psychology: Historical and medical perspectives on dissociative disorders*. New York, NY: Palgrave Macmillan.

Orne, M. T. (1962). Problems and research areas. In Group for the Advancement of Psychiatry (Ed.), *Medical uses of hypnosis* (pp. 676–689). New York, NY: Group for the Advancement of Psychiatry.

Orne, M. T. (1965). Undesirable effects of hypnosis: Their determinants and management. *International Journal of Clinical and Experimental Hypnosis*, *13*, 226–237.

Phillips, M., & Frederick, C. (1995). *Healing the divided self: Clinical and Ericksonian hypnotherapy for post-traumatic and dissociative conditions*. New York, NY: Norton.

Raz, A., Fan, J., & Posner, M. (2006). Neuroimaging and genetic association in attentional and hypnotic processes. *Journal of Physiology*, *99*, 483–491.

Shor, R. (1959). Hypnosis and the concept of the generalized reality orientation. *American Journal of Psychotherapy*, *13*, 582–602.

Spiegel, D., Hunt, T., & Dondershine, H. E. (1988). Dissociation and hypnotizability in posttraumatic stress disorder. *American Journal of Psychiatry*, *145*, 301–305.

Spiegel, H., & Spiegel, D. (2004). *Trance and treatment* (2nd ed.). Washington, DC: American Psychiatric Press.

Stutman, R. K., & Bliss, E. L. (1985). Post-traumatic stress disorder, hypnotizability and imagery. *American Journal of Psychiatry*, *142*, 741–742.

Shaw, G. G. (1931). *Immaturity*. London, England: Constable and Company.

Watkins, J., & Watkins, H. (1997). *Ego states: Theory and therapy*. New York, NY: Norton.

Zerubavel, E. (2007). *The elephant in the room: Silence and denial in everyday life*. New York, NY: Oxford.