Different Perspectives on Informed Consent and Clinical Hypnosis

Edward J. Frischholz
Rush North Shore Medical Center

I had hoped that Dr. Steven J. Lynn’s proposals (Lynn, 2001a; 2001b) regarding informed consent and clinical hypnosis would stimulate some interesting discussion about this important issue and I was not disappointed. However, Dr. Lynn seems to feel that the commentators (Hammond, Scheflin & Vermetten, 2001; Kluft, 2001; Spiegel, 2001; Watkins, 2001) did not accurately understand nor represent his views on this topic. I believe that Dr. Lynn is probably right in this regard because he never explicated exactly what his position is regarding how and when to implement specific informed consent procedures when doing clinical hypnosis. Thus, the real point of contention, in my opinion, does not appear to be whether some type of informed consent should be used; but rather what patients should be informed about.

As I understand Dr. Lynn’s proposal, he seems to be arguing that patients should be informed that: 1) “hypnotic memory recovery techniques” are necessarily dangerous because they have been found to produce significantly more “false” memories in laboratory subjects than non-hypnotic memory recovery techniques; and 2) Ego State therapy techniques (as described by Dr. Watkins) are significantly more dangerous than other therapy techniques because they might induce “false” beliefs about the nature of one’s personality. Both of these assertions are examined in detail below.

“Hypnotic Memory Recovery Techniques” Produce Dangerous False Memories

It seems that Dr. Lynn’s position on this issue appears to be based on three points: 1) “false” memory reports (which seem to be quite different from actual changes in memory) have now been found to be more prevalent than was previously thought; 2) “hypnotic memory recovery techniques” produce significantly more “false” memories (and other memory problems) than non-hypnotic memory recovery techniques; and 3) “false” memories produced by “hypnotic memory recovery techniques” are necessarily dangerous.

Request reprints from:
Edward J. Frischholz, PhD
6301 North Sheridan Road, #23G
Chicago, IL 60660
“False” Memory Reports

The issue of “false” memories has been a highly provocative and controversial topic during the last decade. The recent focus on “false” memories perhaps stems from the empirical work of Elizabeth Loftus (e.g., Loftus, 1979) who found that approximately 25% of subjects exposed to false information about a past event later evidenced a “false memory report” about that event. Loftus (1979) further argued that once a person’s memory was altered in such a way, then this altered memory was permanent. Based on her prior research, Loftus (1993) later seemed to argue that certain therapy practices probably created “false” memories in the clinical context.

However, other research (e.g., McCloskey & Zaragoza, 1985) later showed that so-called “false” memory reports obtained using Loftus’ experimental paradigm may have instead induced a reporting bias. Using a different final recognition test, McCloskey and Zaragoza (1985) further demonstrated original memories were not permanently altered by exposure to post-event information and the rates of “false” memory reports observed in laboratory subjects dropped to less than five percent. Thus, the prevalence of “false” memory reports seems to depend on the type of experimental paradigm employed to produce them.

My doctoral dissertation (Frischholz, 1990) also examined the source of “false” memory reports and found that the type of initial encoding of a target detail (e.g., accurate, inaccurate or not at all) significantly interacted with the type of post-event information exposure (e.g., false, neutral or true) in producing later “false” memory reports using a Loftus-type paradigm. In other words, there may be pre-existing false memories about past events because subjects never accurately perceived all the details in these events in the first place. Thus, the source of false memories may not necessarily be exposure to “false” post-event information (or some type of therapy technique). Other factors may cause a person to have a less than perfect recollection about a past event. Collectively, I believe the empirical evidence regarding “false” memories now demonstrates that they are context dependent and have many causes other than just exposure to post-event information (or a particular memory recovery or therapy technique). Furthermore, Brown, et al. (1998) have argued that demand characteristics seem to be the greatest source of “false memory reports” in “false memory experiments.” Their argument is based on their observation that laboratory subjects, in some of these types of “false memory experiments,” seem capable of distinguishing the original memory from the suggested memory in almost all cases.

“Hypnotic Memory Recovery Techniques produce significantly more “False” Memories

I am not sure what Dr. Lynn means by the term “hypnotic memory recovery technique.” I have argued elsewhere (Frischholz, 1995; 1997; 2000; Frischholz & Spiegel, 1983) that it is misleading to characterize hypnosis as a therapy (e.g., “hypnotherapy”) or as a specific type of treatment. If one accepts this proposal, then it clearly follows that hypnosis is also not a “memory recovery technique” in and of itself. Rather, different types of memory recovery techniques can be used with (or without) hypnosis. Unfortunately, very few types of memory recovery techniques have been empirically studied with hypnosis.

Dr. Lynn (2001a; 2001b) has reasserted his belief that sufficient empirical evidence conclusively demonstrates that all “hypnotic memory recovery techniques” will produce significantly more “false” memory reports (and other memory problems) than non-hypnotic memory recovery techniques. In other words, he seems to be saying that the risk for producing “false” memories significantly increases whenever any memory recovery technique is used with hypnosis. I have expressed my belief above that only a few memory recovery techniques have been empirically studied with hypnosis. Based on this belief, I
think it is an overgeneralization to say that evidence exists, which supports the contention that all memory recovery techniques significantly increase the risk of “false” memory reports if they are used with hypnosis.

I would also like to emphasize that Dr. Lynn’s assertion about the significant “false” memory risk he associates with “hypnotic memory recovery techniques” is by no means universally accepted in the clinical or scientific community. Others (Hammond et al, 1995; Brown, Scheflin & Hammond, 1998) have argued that there is little or no empirical evidence demonstrating a causal link between hypnosis and “false” memories based on evaluating many of the same studies cited by Dr. Lynn.

**Hypnotically Produced False Memories are Necessarily Dangerous**

Based on my interpretation of Dr. Lynn’s initial comment (Lynn, 2001a), I thought that he was arguing that hypnotically-produced “false memories” are necessarily dangerous. However, in his rejoinder (Lynn, 2001b), Dr. Lynn clarifies that he does not believe that “false memories” (whether produced hypnotically or non-hypnotically) are necessarily dangerous.

**The Dangers of Ego-State Therapy**

Again, as I understand Dr. Lynn’s proposal regarding Ego-State therapy (as described by Dr. Watkins), he seems to believe that it is dangerous because it may induce “false” beliefs about the nature of a patient’s true underlying personality. I believe his argument is based on just what should be considered a “true” or a “false” characterization of personality. I do not think any one theorist, scientist or clinician has cornered the whole market on this issue. Different therapy techniques are based on different conceptualizations of personality and pathology.

Dr. Lynn asserts that laboratory evidence on experimental subjects has shown that some treatments (which he appears to think are analogous to some Ego-State therapy techniques) may induce new and different (“false?”) beliefs about one’s personality. I do not agree with his implicit assumption that the experimental treatments he considers are in any way analogous to the Ego-State therapy techniques described (or used) by Ego-State therapists trained in Dr. Watkins treatment methods.

There is absolutely no evidence that Ego-State therapy techniques are (in any way) dangerous. Dr. Lynn is certainly correct that there is also no empirical evidence that Ego-State therapy effective, other than the outcome data anecdotally reported by the Watkins. Obviously, such empirical work would be desirable.

**Implications for Informed Consent Practices**

Collectively, what implications do these issues have for what patients should be informed about when doing any type of memory work with clinical hypnosis? Should patients be specifically informed that memory is contextually dependent and fallible for a variety of reasons? Should patients be informed that there is no universal agreement about the effects of hypnosis on memory? Finally, should patients be told that if clinical hypnosis were to produce a “false” memory during a course of therapy, it would not necessarily be dangerous?

Likewise, should potential patients about to undertake a course of Ego-State therapy (as described by Dr. Watkins) be informed that it might confuse them about the true underlying nature of their personality? Should such patients also be informed that there is no empirical evidence demonstrating that Ego-State therapy techniques are dangerous?
Perspectives on Informed Consent and Clinical Hypnosis

Beahrs and Gutheil (2001) have recently reviewed the literature on informed consent and offered their evaluative comments and suggestions about how to develop effective informed consent procedures. Their discussion highlights the point that a focus on the idea of informed consent is only the beginning point of a cogent analysis, not its conclusion. What matters is what the form says and how it is presented to the patient. In recent legal cases, lawyers advocating what has been called “the false memory” position have claimed that an informed consent form is invalid unless it identifies hypnosis as “dangerous,” “experimental,” and “unproven” by long-term outcome studies. Does Dr. Lynn advocate the use of such language? If not, even the forces in society that have been pushing most strenuously for informed consent when memory is refreshed with hypnosis will find Dr. Lynn’s proposals regarding the use of consent forms to be a failure because they do not properly “inform.”

I believe that we have reached wide agreement that engaging in some type of informed consent practice before beginning any kind of clinical interaction is highly desirable and perhaps ethically necessary (Nagy, 2000). For example, the current Ethical Guidelines of the American Psychological Association (APA, 1992) state that all psychologists in either a clinical or research context should attempt some type of informed consent. However, there are no set practices for how/when such informed consent should be obtained; only general guidelines which allow for broad interpretation and implementation. I think it would be productive if practitioners of clinical hypnosis now start to examine just what type of informed consent procedures would be desirable. The Guidelines on Hypnosis and Memory developed by the American Society of Clinical Hypnosis (Hammond, et al 1995) were a significant new step towards reaching this goal. Hopefully, more work will be done on this issue in the near future.

References


