Reply to Lynn:
The Trojan Horse is Alive and Well

Richard P. Kluft
Temple University School of Medicine

In his brief communication, Lynn represents himself as providing additional “caveats regarding the potential risk of pseudomemories and the dangers of reifying metaphors offered to clients in the process of clinical hypnosis,” correcting an oversight in a previous communication on the hidden observer (Lynn, Mare, Kall, Segal, & Sivec, 1994). He indicates that phenomena that he designates as metaphors, such as hidden observers, inner advisors, and ego states, etc., are “in no way true personality fragments or independent identities with distinct past histories.” Instead, they are “merely metaphors for the fact that different experiences and perspectives…can be accessed when situational demands are conducive to examining one’s life in fresh ways.” He wants to be sure that patients are unlikely to perceive these phenomena as more than metaphors before any intervention using such phenomena as metaphors is undertaken. He believes that such metaphors should never be used in the context of age regression for memory recovery and that age regression should not be used in the exploration of memory. By implication, many venerable hypnotic techniques should be eliminated from our armamentarium, or their use should be reduced drastically and/or surrounded with special caveats and additional exercises in the obtaining of informed consent.

It was very appropriate for Dr. Lynn to repeatedly express his recommendations as beliefs. He advances opinion rather than data in their support. However, he would have been more true to the tenor of his argument on the importance of informed consent had he then educated his readership evenhandedly about both the potential benefits and liabilities associated with employing his beliefs to guide their practice. He has spoken strongly against these techniques without demonstrating that the problems associated with them outweigh their potential benefits. In taking this stance, his contribution joins many others by scholars concerned about the potential for the distortion of memory in the course of clinical work, contributions which, in this era of “memory wars,” have repeatedly taken leaps from the notion that a certain outcome is possible, to the thought that is it probable, to the conviction that it will occur at a high degree of frequency, to the certainty that it has occurred or will occur in a given case. Draconian recommendations for restrictions on the use of hypnosis in general, and particular hypnotic techniques, drawn from polarized perspectives, have become commonplace, and prematurely disambiguate a number of very complex and incompletely understood areas. Some commentators have observed that in such instances, the cure is worse than the disease, and the search for the perfect becomes the enemy of the good.

Address communications to:
Richard P. Kluft, MD
111 Presidential Boulevard, Suite 231
Bala Cynwyd, PA  19004
RPKluft@aol.com
In general, informing clinical practice with research findings is desirable (Lynn, 1994). However, this is desirable only if the research findings are clear, demonstrate ecological validity, and have not been used as springboards for overgeneralizations. The present contribution presents neither data nor arguments that are compelling. We very much need more relevant research. For example, it would be interesting to do follow up studies on the subjects of the type of research to which Dr. Lynn refers in order to see if the type of “hidden observer” interventions that were done have had lasting effects of any sort. Shouldn’t we know whether any of these subjects now suffer from a dissociative disorder clearly attributable to Dr. Lynn and his colleagues before we assume the potency of these or similar interventions to accomplish this or far worse in a clinical setting?

Let us proceed to other concerns. Dr. Lynn has presented his beliefs and opinions. He has recommended that we adopt suggestions based upon them. Since the data are not compelling, we must be quite careful in our inspection of the arguments that have been made. I find it useful in studying the underpinnings of all similar recommendations to regard the recommendations and the assumptions inherent in the argument that has been made as if they were potential Trojan horses. That is, it seems prudent to consider what unsuspected contents might be lurking, hidden within and beneath their manifest statements, before I welcome them, their constructions of reality, and the clinical recommendations that flow from them, into my consulting room.

Within Dr. Lynn’s arguments are several assumptions or implications. Here, I will address only eight. (The informed reader may be sensitive to many others, and consider them of greater importance than the ones that I have selected.) I apologize to Dr. Lynn if the brevity of his communication forced him to express himself in a way that he may feel I have misinterpreted. The eight assumptions or implications are:

1. The hidden observer phenomenon has been demonstrated to be no more than an imaginative creation shaped by social demands and expectancies.

2. It has been demonstrated that ego states (among other phenomena) are not freestanding phenomena, but are always created by social demands and expectancies.

3. Several types of phenomena are virtually equivalent, and what is true for one is true for all. Hence, hidden observers, inner advisors, ego states, and the various synonyms for alter personalities can be discussed together without doing an injustice to any of these phenomena, and recommendations and concerns appropriate for one are appropriate for all.

4. An informed consent document for procedures involving the hidden observer phenomenon and phenomena, assumed by Dr. Lynn to be analogous to it, should include caveats based upon assumptions 2 and 3.

5. It has been demonstrated that the iatrogenic creation of dissociative identity disorder can be developed from the use of a hidden observer metaphor or by verbalizations that address, invite, or mobilize similar phenomena, which may be reified by the patient.

6. The cost-benefit ratio of the use of the techniques eschewed by Dr. Lynn has been established, and it is clear that they are predictably dangerous to the
degree that they should be abandoned or used only with considerable restrictions and with warnings.

7. The social-psychological or socio-cognitive paradigm has achieved such ascendancy that all other paradigms of understanding may be dismissed or regarded as minor voices.

8. The aggressive expansion of the domain of informed consent into therapeutic settings and its specific application to particular interventions and procedures is a constructive development, which will be without significant negative consequences.

There are problems inherent in all of these assumptions, none of which are based on evidences that compel their acceptance. I will address each briefly, acknowledging that every one deserves a much more comprehensive consideration.

It is not all clear that the hidden observer phenomenon is no more than a metaphor. Many scholars with impeccable credentials have argued and continue to argue for a neodissociation as opposed to the sociocognitive orientation in understanding it. This debate is captured nicely in Lynn and Rhue’s *Theories of Hypnosis* (1991).

It is by no means clear that ego states and allied phenomena are invariably the outcome of suggestion and demand characteristics rather than freestanding phenomena. Certainly ego states can be activated or mobilized easily. Several schools of therapy (e.g., ego state therapy, transactional analysis, gestalt therapy, and psychodrama) depend on this capacity. However, many conditions and phenomena involving ego states occur naturalistically.

It is very questionable whether the many phenomena lumped together by Lynn are sufficiently similar to receive similar treatment. At risk of overgeneralizing, Hilgard’s original “hidden observer” instructions elicited the phenomenon in about half of high hypnotizables. The rather different types of instructions used by Spanos and Lynn and others are capable of eliciting verbalizations of somewhat similar phenomena in 90-100% of subjects. It is very dangerous to generalize from studies that suggest basically ego-syntonic, constructive or neutral transient, situation-limited ego state phenomena in nearly all normal subjects to the implicit assertion that basically ego-dystonic, psychopathological, disruptive and longstanding alter personality phenomena can be created in a significant number of psychiatric patients from similar interventions.

Since it is difficult to sustain the notion that ego-state phenomena are invariably the result of suggestion and the demand characteristics of particular situations, it seems premature to include such caveats in an informed consent document. In fact, such a warning might have a chilling effect on a patient with as yet undeclared ego state phenomena, who would be in a real double bind about making revelations about their circumstances, feeling that anything they might reveal about their ego states would be discounted in advance.

The allegations that dissociative identity disorder (DID) can be created iatrogenically remain hotly debated and controversial. It is clear that many phenomena of DID can be created in laboratory settings (Spanos, 1994); that DID can become more complex in response to clinical misadventures (Kluft, 1982); and that expectation and suggestion can cause patients with DID to create additional alters to conform to their therapists’ theories and beliefs, if those beliefs are ego-syntonic to the patients (Kluft, 1989). However, it is not equally clear that maneuvers such as those about which Dr. Lynn warns are capable of creating DID in a
subject or patient with no previous evidence of a dissociative disorder. Even Ross (1997), who believes in the possibility of iatrogenic DID, maintains that many interventions, over a long period of time, are necessary to effect this. Notwithstanding judicial decisions in which the concept of iatrogenesis is explicitly or implicitly endorsed, there is insufficient scientific data to assume that iatrogenesis occurs, or if it occurs, how commonly this occurs and under what circumstances.

Furthermore, it is not clear that the techniques in question have a predictable degree of dangerousness of the sort that concerns Dr. Lynn. I am prepared to consider that any intervention may at times have unwanted side effects, but I am not prepared to surround that intervention with cautions and warnings without knowing the frequency and severity of possible adverse outcomes. Informed consent is not usually construed to involve acquainting the patient with every possible unfortunate outcome, only those of great severity and considerable frequency. More information is necessary to clarify whether the techniques in question really deserve such warning labels.

Dr. Lynn’s argument is premised on a certain paradigm of understanding, which some would label socio-cognitive or social-psychological. Proponents of paradigms often conduct themselves as if they were the agents of the manifest destiny of that paradigm, charged with sweeping away all that preceded or opposes their paradigm of choice (Kuhn, 1970). Again referring to Lynn and Rhue (1991), there are many paradigms available within which to conceptualize and study hypnotic and dissociative phenomena. Dr. Lynn’s recommendations stem from one available model, which has been challenged for its adequacy in addressing all relevant research and clinical observations. Whether this model is the only or the correct one for understanding the clinical interventions in question is open to debate.

Finally, it is not at all clear that the aggressive expansion of informed consent considerations to encompass specific techniques and interventions is a positive contribution. Paul Fink (1999), a former president of the American Psychiatric Association, has written with passionate eloquence about the negative consequences of the intrusion of such efforts into the therapeutic relationship. Many legal statutes that describe informed consent requirements include the exception that when obtaining informed consent may be destructive to the patient’s health it may be justifiably omitted. When I teach about informed consent in workshop settings, I often am told of incidents in which patients exposed to a full spectrum of informed consent warnings are being scared out of therapy. This has happened once in my own practice. The patients in these anecdotes who left unsettled and untreated were not, in my judgment, the so-called reasonable persons hypothesized in legal discussions of informed consent, who made thoughtful decisions against treatment. Instead, they were terrified and demoralized individuals hoping to find sanctuaries and places of healing in their clinicians’ offices, who were frightened by what they heard to the extent that they believed treatment would further traumatize them. I wonder whether the aggressive expansion of informed consent now being introduced into psychotherapy in general and hypnosis in particular goes beyond what is reasonable and creates a situation that violates the Hippocratic axiom of “primum non nocere,” that is, “firstly, do no harm.”

In Dr. Lynn’s current contribution and the article of which it is a sequel (Lynn et al., 1994) we learn of three aspects of his professional activities. He is a clinician, a researcher, and a forensic expert. I wonder whether this contribution was driven more by Steven Lynn the forensic expert than by Steven Lynn the researcher or Steven Lynn the clinician. I would invite Dr. Lynn to undertake further studies that will demonstrate the fruits of efforts of the scholarly integration of “The Three Faces of Steve”.

300
References


