Age Regression: Tailored versus Scripted Inductions

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The effects of tailored versus scripted hypnotic inductions were tested with the intention of shedding light on age regression phenomena. From an initial pool of 31 volunteers, 10 males and 10 females who scored 3 or better on the Stanford Hypnotic Clinical Scale, participated in this study. Participants were assigned to either scripted or tailored hypnotic induction conditions for regression to age 5. The age specific developmental task was to indicate for each of 10 abstract figure pairs, which of each pair “was upside down”. Both groups showed significant focal point dependency. However, the tailored induction group showed significantly greater focal point dependency characteristic of 5-year-old children, in contrast to the scripted induction group. It appears that tailored hypnotic inductions may provide a better avenue for the ego to regulate its own degree of regression. The better match to personality style takes advantage of the naturally occurring ego-syntonic capacities of the participant, thereby facilitating greater hypnotic responsiveness.

Key words: Age regression, hypnotic inductions, hypnoanalysis

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1 On the basis of a national survey of preferences for descriptors of hypnosis (Christensen, 2005) “hypnotic state” and “hypnotizability” are employed in this article.

2 We wish to thank Elgan Baker and Deirdre Barrett, PhD. for their comments on an earlier draft of this article.
Barabasz and Watkins (2005) point out that scripted hypnotic inductions, particularly scripted inductions administered by those with little clinical experience with hypnosis are unlikely to produce genuine hypnotic responsiveness. In such instances, significant findings are also unlikely, but if found, may be limited to those that could be produced by nothing more than simple suggestion or social influence rather than the more profound responses producible by hypnosis per se. The statement was not intended to belittle or minimize the sometimes therapeutically valuable results that can be wrought by suggestive procedures alone. Rather, we wish to emphasize that writings under the umbrella of “hypnosis” by “hypnosis researchers” frequently do not include efforts to induce genuine hypnotic responsiveness, take the clinically sensitive steps needed to assure depth sufficient for the sought response, or individualized to the hypnotic talents of a unique patient or research participant. Barabasz and Watkins explain further that in such instances it should not be surprising to anyone that no statistically significant findings are revealed that could not have been produced by means other than hypnosis.

The literature on hypnosis is contaminated by a proliferation of such studies which have no doubt misled a number of researchers and less experienced clinicians to misconstrue the reality of veridical hypnotic phenomena. As McConkey (2004) noted, to facilitate true hypnotic responding we must try to understand hypnosis from the experiences of the participant rather than the point of view of the researcher. Hypnotic inductions, tailored to the individual participant on the basis of clinical experience with the phenomena, combined with some knowledge of the participants’ personality style may be one way of approaching this problem. Unfortunately, little controlled research has been directed toward determining the effects of clinician experience on treatment outcomes or the use of tailored versus scripted inductions.

Green and Lynn (2000) comprehensively reviewed the effects of hypnosis and suggestive procedures for smoking cessation. A wide variation in success rate (about 20 to 54%) at follow-up was found, but only one study included data on clinician experience (Barabasz, Baer, Sheehan, & Barabasz, 1986). In the Barabasz et al. study, 307 patients participated in 1 of 7 alternative treatment groups. Those exposed to individualized and more comprehensive hypnosis by psychologists and psychiatrists with several years experience using hypnosis showed over four times better results (47% abstinence at 19 months follow-up) than those receiving manualized (scripted) hypnotic inductions or tailored inductions from clinical psychology interns with minimal training in hypnosis (4% abstinence rate at 4 months follow-up). Bergin and Garfield (1994, p. 171) raise the concern as to why so few psychotherapy studies and reviews address the issue of therapist experience. However, citing Barabasz et al. (1986), Carey and Burisch (1987) and Lyons and Woods (1991) note that when the issue has been addressed, the outcomes favor highly trained therapists over less trained therapists. The renowned hypnoanalytic therapist, John G. Watkins (2004), reviewed this state of affairs noting, that few clinicians publish and the vast majority of studies extant in the literature come from academics with minimal, if any, clinical experience who use even less experienced graduate students to conduct the hypnotic

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1 Genuine hypnotic responsiveness refers to responses obtained after administration of a hypnotic procedure (Nash, 2005) that cannot be produced by suggestion without hypnosis or role playing (Barabasz, 2000); such responses may also be referred to as “true hypnotic responding” and “veridical hypnotic phenomena”.  

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interventions using nothing more than scripted inductions. There is literature suggesting just the opposite position as well (Christensen & Jacobson, 1994) with inexperienced therapists apparently showing similar outcomes as experienced clinicians. A close review of this group of studies is revealing. For example, professional experienced therapist’s often had less than 5 years’ experience. The level of severity of a disorder was sometimes less for inexperienced therapists or perhaps trivial for both groups. Strupp and Hadley (1979) selected inexperienced participants for warmth, trustworthiness, etc. and used college students described as disturbed, but apparently without a clinical diagnosis for the patient population.

To assess the affects of clinical experience and that of tailored versus scripted hypnotic inductions, Barabasz, Barabasz, Lin-Roark, Roark, and Christensen (2003) focused on one of the more profound phenomenon facilitated by hypnosis—age regression. A half-century earlier, Orne (1951) attempted to test the reality of the phenomenon using university students regressed to the age of 6. Both Rorschach records and handwriting samples were taken. The hypnotically regressed Rorschach responses were “always substantially different from the control records.” Consistent with the concepts of trance-logic and dissociation where a truly hypnotized person remains, in part, in contact with reality, Orne noted that a subject raised in Germany responded initially in English when regressed to age 6. Nonetheless, his Rorschach responses were at the childish form level and content, but with no apparent change in other organization. Such ablation of personality, unless brought about by, for example, spontaneous dissociation due to trauma, is generally thought to require procedures sufficient to induce deep hypnosis. As Orne (1951) stated, “If a person under deep hypnosis is told that he is 6-years-old then his behavior will be strikingly similar to that of a child of 6. This implies that individual functions at the suggested age level, all knowledge acquired after that age is absent, and the subject’s reactions to both familiar and unfamiliar situations are fully congruent with his behavior potentialities when he was that age.”

The age regressed handwriting samples were very different from those of the adult subject, but not identical to genuine childhood samples done at age 6. Cautiously, Orne concluded that the findings gave no evidence of “complete regression”. Unfortunately, the Rorschach responses obtained in Orne’s study were not scored using criteria with established reliability. Furthermore, the assumption that the regressed writing and drawing samples should be identical to those produced by the participant when they were age 6 is unfounded. The adult hand size and advanced fine motor coordination and development of the adult participant due to physical maturation would essentially preclude this. It seems to the present authors that absolutistic criteria for regression phenomena were used with measures that, as scored, were ripe with poor psychometric properties. We also know of no data, nor even a theoretical framework, that suggests that regression by hypnosis must be complete for therapeutic goals to be reached. Quite to the contrary, Nash’s (1987) comprehensive review of the empirical literature on hypnotic age regression explains that hypnotically regressed adults do not go back in time. They experience a shift toward more prelogical primary process modes of thinking. As pointed out by Freud (1917/1953), the shift is topographical rather than temporal.

In the only regression studies that Kihlstrom (1985) considered to be adequately designed, Nash, Johnson, and Tipton (1979) and Nash, Lynn, Stanley, Frauman, and Rhue (1985) showed evidence of essentially complete reproduction of childlike personality functioning. Crawford, Wallace, Katsuhiko, and Slater (1985) also reported the reinstatement of eidetic imagery, found in children but not adults, for high but not low hypnotizable participants. Unfortunately, only about 10% of children are eidetic (Walker, Garrett, & Wallace, 1976). Given these intriguing findings we sought to use a developmental marker displayed by the
majority of children as well as one that could not be role-played by a hypnotically age regressed adult.

Dodd and Strang (1966) conducted a pilot experiment to investigate children’s perceptions of abstract figure inversion. Primary children (ages 6 to 8 years) were found to differ significantly from preprimary children (ages 4 to 5) in their determination of inversion perception in their choices of figures in response to the question: “Does it look upside down?” Unlike the measures used in the studies of age regression reviewed above, Strang’s test had demonstrated test– retest reliability ($r=.92$, Dodd, 1976). Barabasz and Dodd (1978) found that children about 5-years-old uniquely show significantly greater focal point1 dependency in their determination of whether or not an abstract figure (which has no true right side up) is perceived as inverted.

This unique and statistically pervasive developmental feature provided a way of testing the effects of both clinician experience and type of hypnotic induction. The Barabasz et al. (2003) study used 20 university student volunteers who had all passed the age regression item and had scored 3 or better on the 5-point Stanford Hypnotic Clinical Scale (Morgan & Hilgard, 1975). Using a counter-balanced design 10 participants were exposed to a hypnotic induction for regression to age 5 by Ph.D. students with 60 hours of training in hypnosis and experience of about 100 to 150 inductions. The other 10 participants were seen by licensed psychologists who had conducted a minimum of 30,000 hypnotic inductions. The groups were further counterbalanced to test scripted hypnotic inductions versus tailored hypnotic inductions. The experienced clinicians evoked significantly greater evidence of age regression to 5 years where the participants produced focal point dependency responses, which were not significantly different from those produced by 5-year-olds. The Ph.D. students were ineffective in producing such age regression effects. Unfortunately, counterbalancing tailored and scripted inductions at both levels of experience reduced cell sizes to only 5 subjects (Ss) in each condition (experienced clinician 10Ss, 5 tailored X 5 scripted and Ph.D. students 10Ss, 5 tailored X 5 scripted). The small cell sizes precluded drawing statistical inference from the data regarding the effects of scripted versus tailored inductions.

Given the previous finding that only experienced clinicians were able to produce focal point dependency consistent with that of 5-year-old children, the two-fold purpose of the present study was to determine whether tailored hypnotic inductions are superior to scripted hypnotic inductions and to attempt to shed light on the age regression phenomenon in a laboratory context.

**Method**

**Participants**

Thirty-one university community volunteers served as participants. After debunking myths about hypnosis and brief exposures to hypnotic-like experiences (ie. Chevreul’s pendulum swing, arm drop, etc; Barabasz & Watkins, 2005), the Stanford Hypnotic Clinical Scale (SHCS) was administered by the second author. As in the Barabasz et al. (2003) study, only those passing the age regression item with a total score of 3 or better were asked to participate further in the research. This resulted in a final $n$ of 20 participants (10 females, 10 males; age range 17 to 52 years).

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1 Focal point is operationally defined as an irregularity in a figure’s contour as exemplified by the angle of a V, the point of intersection of a T, or the rounded portion of a crescent.
Procedure

Participants were assigned to either the scripted hypnotic induction (SI) group or the tailored induction (TI) group by alternating treatments according to time of volunteering for the study. Given that a simple initial suggestion can constitute a hypnotic induction for hypnotizable individuals (Nash, 2005), the potential for spontaneous hypnosis (Barabasz, 2000, 2005/6) and the fact that a non-hypnotic (waking state) control group would add little if anything to the focus of the study (Hilgard & Tart, 1966) while increasing the risk of a type II error in both groups involved in hypnosis (Barabasz & Barabasz, 1992) there was no work control group. All were seen in the Attentional Processes/Hypnosis Laboratory at Washington State University.

The age regression induction for the SI group consisted of the standard induction read verbatim by the first author from the SHCS. The SHCS induction was chosen for the scripted condition because the participant had shown hypnotic responsiveness to it in the pretesting phase sufficient to produce an above average total score and a passing score on the age regression item. After the induction was read, the age regression induction, from item number three, was read, but this time the instruction was to return to kindergarten at the age of 5. “You are now 5-years-old in kindergarten on a happy day.” The participants’ perception of regression to age 5 was confirmed by positive answers to the questions: “Where are you?”, “What are you doing?”, “Who is your teacher?”, “How old are you?” “What are you wearing?”, and “Who is with you?”

Strang’s test (Dodd & Strang, 1966) was then administered by the second author, who was masked as to the focal point down preferences of children age 5. First, knowledge of the concept of inversion was confirmed for all participants using the first two realistic figure items of the Strang test (one depicts a “teddy bear” the other a “flower”). Participants were asked to indicate by pointing with a finger as to which one was upside down. Since we could not assume that all 5-year-olds understand the descriptor “upside down”, the test uses black line on white background drawings of a bear and a flower to test comprehension of the concept of inversion rather than mere rote memorization of a response for spatial orientation of a human figure. The Strang figures are identical except that one is rotated 180 degrees inverted from the other. The remaining 10 abstract figure pairs were then presented in the sequential progression shown in Figure 1.

Figure 1
After test administration, participants were age progressed to their current/true age while remaining in hypnosis. They were told, “you are no longer 5 years old, but an adult [actual age of participant] years old sitting on a couch deeply hypnotized in the hypnosis lab at Washington State University, you are grown up and everything is as it was.” Participants were then awakened from the hypnotic state using the standard instructions from the Stanford Hypnotic Clinical Scale.

The age regression inductions for the TI group were also administered by the first author. The induction type and manner of administration was opined on the basis of clinical experience and clinical intuition gained from observation of each individual participant during the debunking of false beliefs about hypnosis, reactions to pre-hypnotic induction experiences, and responses observed during the second author’s administration of the Stanford Hypnotic Clinical Scale.

The types of inductions varied greatly within the full spectrum range of protocols elucidated in the Barabasz and Watkins (2005) hypnotherapeutic techniques text. One anxious participant, who had achieved just the minimum Stanford Scale Score for acceptance to the study, entered an apparently deep level of hypnosis (method of assessing depth is discussed below) quite rapidly when the authoritarian “Direct Stare Method” (p. 131) was used. A participant, who presented as a narcissistic had expressed “polite” reservations about the reality of the hypnotic experience, was induced into hypnosis indirectly with an adaptation of an Ericksonian approach (pp. 183-184). “Before we do the hypnotic induction I wonder if you would be willing to get up off the couch and please check to see that the ‘Do Not Disturb’ sign is on the door?” (Pause-) “Oh, now please see that the door is completely shut, good!” “And, do try to keep yourself out of hypnosis until you are back on the couch. Yes, please do stay out of hypnosis for just another moment if you can and bring that book to me on your way back to that comfortable couch (observing the slowing of the participant’s motoric actions).” “Yes, thank you for staying out of hypnosis until you reach the couch, (pause) if you really want to you can close your eyes then too.” The participant slumped onto the couch, eyes closed. Using the same depth assessment method used with the other participants (Hilgard, 1979), he was asked to give a number as to how deeply hypnotized he felt. He was then asked to raise a finger when he reached a number which was double that which he indicated, during the intervening 60 to 90 seconds he was encouraged to “only go a little deeper, only as deeply as you want to, but you will always hear me clearly and distinctly no matter how deeply down into hypnosis you go.” Consistent with Erickson’s (Rossi & Rossi, 1976, p. 2) understanding that clinical trance “is a free period in which individuals can flourish, Baker (1983a) pointed out that the hypnotherapy literature suggests that permissive inductions are the most productive for these participants. The approach for this volunteer was taken from a protocol appearing in the Watkins and Barabasz (2005) text in which Matthews, Lankton, and Lankton (1996) emphasize is a key Ericksonian element that attempts to use the strengths, resources, and abilities of the participant. These points regarding induction techniques should not be confused with arguments about the value of indirect vs. direct hypnotic suggestions. Claimed advantages for indirect suggestions to bypass conscious interference have been tested by Van Der Does, Van Dyck, Spinthoven and Kloosman (1989) as well as Lynn, Neufeld, and Mare (1983). No significant evidence favoring indirect individual suggestions was found.

Examples of other inductions included arm levitation, hand opposed arm levitation for resistant responders, eye fixation, muscle relaxation, descent to a safe room, and a tropical island pool relaxation induction procedure (Barabasz & Watkins, 2005).
Although all were varied to accommodate each individual participant’s rate and quality of responding within the context of their personality style, the inductions for both the SI and the TI groups were about 10 minutes in length.

The regression to age 5 was also individualized according to each participant’s manner of responding to hypnosis. The SI group was awakened from the hypnotic state following the SHCS procedure, read verbatim. The same awakening procedure was used for the TI group, however, it was not read verbatim.

**Results**

Participants’ SHCS responses were scored by the standardized criteria. The Strang test responses were scored as correct if the inversion response was elicited on the basis of a figure’s focal point down. The data were analyzed using a fixed-effects model analysis of variance. The hypnotizability test scores between the SI and TI groups were not significantly different (SI $M = 4.2$, $SD = .79$; TI $M = 3.8$, $SD = .76$) ($F =1.7$, $df = 1, 18$; $F = .21$, Eta squared effect size for group = .08).

Significant ($p < .01$) focal point dependency was exhibited by both groups. However, the salient finding was that participants in the tailored hypnotic induction group showed significantly ($p < .0001$) ($M = 9.1$, $SD = .98$) greater focal point dependency, characteristic of five year olds, in contrast to the scripted hypnotic induction group ($M = 6.4$, $SD = 1.6$) ($F = 20.96$, Eta squared effect size for group = .54). The results appear in Figure 2.

**Figure 2: Focal point dependency results for age regression by scripted and tailored inductions.**
Age Regression: Tailored vs. Scripted Inductions

Discussion

Orne’s (1951) study of hypnotic age regression was based on his assumption that age regression must be complete in virtually every respect to support the reality of the phenomenon when brought about by hypnosis. This absolutistic notion contrasts with his later classic work on trance logic where, for example, a person experiencing a negative visual hallucination must see it not to see it, or for analgesia one must feel it not to feel it (Watkins, 1992, p. 267).

Orne’s requirement of completeness is also at variance with earlier concepts of hypnotic age regression where Kris, noting his statements of 1936 and 1949 (1952, p.188), explained “the ego regulates its own capacity to regression [degree of regression] that the organizing functions of the ego include the function of voluntary and temporary withdrawal of cathexis….” Later, Schilder (Schilder & Kauders, 1956, p. 96) observed that all regressions are only partial regressions, “whereas a considerable portion of the personality maintains it’s normal relations with the outside world.” The psychoanalytic conceptualizations of partial attenuation of contact with reality in hypnosis are consistently supported by controlled laboratory experiments of EEG event related potentials, which demonstrate the reality of the hypnotic state (Barabasz & Lonsdale, 1983; Barabasz, Barabasz, Jensen, Calvin, Trevisan & Warner, 1999; Barabasz, 2000; Spiegel, Cutcomb, Ren, & Pribram, 1985; Spiegel, Bierre, & Rootenberg, 1989).

Orne’s failure to find evidence of “complete regression” is not surprising. Baker (2004) notes, “Even in psychopathology we often encounter individuals who show extremely impaired functioning in certain capacities and relatively intact or mature functioning in others.” Unfortunately, Orne’s study provided, at best, nominal data regarding regression responses. Thus, it was difficult to evaluate the degree to which age regression may have been brought about. The present study used an objective test instrument, which provided continuous equal interval data. Furthermore, unlike Orne’s hypnotic requests for participants to produce children’s writing samples, the nature of Strang’s test made it possible to completely mask participants as well as the test administrator (CC) as to the correct test item responses. The effects of scripted inductions could then be tested while shedding some light on the levels of age regression that might be attained with participants known, by virtue of their SHCS test scores, to have the capacity to experience hypnotic age regression.

Replicating our previous findings (Barabasz, et al., 2003), both scripted and tailored hypnotic inductions resulted in statistically significant focal point dependence in inversion perception. However, participants given tailored inductions showed significantly greater focal point dependence evidence of age regression than those exposed to scripted inductions. The age regression phenomenon requires that deep hypnosis be achieved (Orne, 1951). Consistent with Jensen and Barber (2000), it appears that a tailored approach is the method of choice, when difficult hypnotic responses are to be obtained. A tailored induction may help enhance security by providing a more empathetically attuned interaction and a greater degree of containment for the participant’s phenomenology. It may be that the greater congruence is achieved by a better match to the participant’s personality, as well as their manner of thinking and feeling, thereby, taking advantage of naturally occurring ego syntonic capacities to produce greater hypnotic responsiveness. As Baker (1983b) explains, the hypnotherapist demonstrating a greater sensitivity may pull for a more positive transference, which is often associated with a greater degree of iatrogenic regression.
It is noteworthy that given our previous study’s inability to point to such an advantage for tailored inductions and recent data (Palsson, 1998, in press; Palsson, Tuner, Johnson, Burnett, & Whitehead, 2002) showing high and long lasting success rates with a scripted approach for irritable bowel syndrome (IBS) our expectations, if any, likely favored the scripted approach. These factors, may in part, make up for the limitation of having only a single clinician administer the age regression inductions to age 5. Perhaps scripted inductions are adequate to produce desired hypnotic effect and clinical outcomes in cases where a greater degree of hypnotic depth or responsiveness is not required such as for the majority of IBS cases (Palsson, et al., 2002). Further research will provide answers.

Our data showed that age regression could be produced by hypnosis of a sufficient extent to produce participant responses that coincide with the developmental stage sought by the hypnotically suggested age level. It was virtually impossible for participants to guess the correct answers, nor could the test administrator (CC) provide clues by social influence as to the correct answer as she was masked with respect to the scoring criteria.

Despite our positive findings, caution is advised in extrapolating to other, more complex forms of age regression, which may be required in clinical settings involving therapeutic influence as well as hypnosis. However, it is equally, if not more important to recognize that neither these findings nor those of Orne necessarily have any bearing on the psychotherapeutic efficacy of age regression by hypnosis. As Orne mentioned, the process of catharsis is clearly aided by hypnotically reconstructing a patient’s past. Obviously, such a reconstruction need not be founded in historically accurate representations. The material brought up by the patient experiencing hypnotic age regression will likely have sufficient subjective validity to be of substantial clinical value.

References


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