

**Current Practices, Experiences, and Views in Clinical Hypnosis:
Findings of an International Survey**

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Abstract

An online survey of 691 clinicians who use hypnosis was conducted in 31 countries to gain a broad real-world picture of current practices, views, and experiences in clinical hypnosis. Among 24 common clinical uses, stress reduction, wellbeing and self-esteem-enhancement, surgery preparations, anxiety interventions, mindfulness facilitation, and labor and childbirth applications were the most frequently rated as highly effective (each by $\geq 70\%$ of raters) in the clinicians' own experience. Adverse hypnosis-associated effects had been encountered by 55% of clinicians but were generally short-lived and very rarely judged as serious. The most common hypnosis approaches used were Ericksonian style (71%), hypnotic relaxation therapy (55%), and traditional hypnosis (50%). Almost all respondents reported regularly using other therapeutic modalities alongside hypnosis. Among a range of client variables potentially affecting therapy, most clinicians rated hypnotist-client rapport (88%) and client motivation (75%) as very or extremely important factors for successful hypnotherapy. The majority of respondents had conducted hypnosis treatment via teletherapy, and 54% of those estimated it to be as effective as in-person treatment.

Current Practices, Experiences, and Views in Clinical Hypnosis:

Findings of an International Survey

Clinical hypnosis has been widely practiced for more than a century, and many thousands of therapists are currently offering hypnotherapy services in countries around the world and treating a broad spectrum of ailments and presenting problems. In spite of this extensive use, very little has been documented in the empirical literature about the general nature of these practices or the collective clinical experience of the hypnosis practitioners. Published clinical hypnosis research has mostly concerned itself with interventions that are separate from real-world clinical practice, often conducted in highly specialized clinics or academic environments. These research interventions are likely to be carried out by therapists who have different backgrounds, training, and therapeutic styles than those in the general clinical hypnosis community, and the clients treated in such studies are not necessarily representative of the typical hypnotherapy client. Although more direct observations from routine clinical hypnotherapy sometimes do enter the hypnosis literature, they tend to range from single case reports to case series, neither of which are suited to give a broad picture of common patterns of practice in clinical hypnosis.

In the instances where surveys have been applied to assess the collective experience and perspectives of large groups of hypnosis clinicians, they have often been narrowly focused on individual topics, such as treatment of depression (Hensel et al., 2001), dissociative identity disorder and false memory (Ost et al., 2013), theoretical influences and hypnosis styles of therapists (Rodolfa et al., 1985), use of hypnotizability testing in clinical practice (Channon, 1983), motivations for learning and practicing hypnosis (Meyerson et al., 2019), or trends in

planned research (Fromm, 1979). Only a small number of survey studies have been published that more broadly reflect clinical practices and perspectives of groups of hypnosis clinicians.

The earliest of those studies, conducted by Levitt and Hershman (1963) in the United States (U.S.), summarized responses from 301 clinicians who used hypnosis. The sample primarily comprised physicians and dentists. The authors reported that the most common hypnosis applications used by the survey respondents were interventions for anxiety, situational/adjustment issues, habit control, psychosomatic problems, and pain control. Adverse or unusual reactions were reported by 27% of the clinician sample, most often negative affective responses including anxiety, panic, or depression.

Pulver and Pulver (1975) interviewed 101 physicians and dentists in the Philadelphia area of the U.S. who had completed a hypnosis training course several years earlier and found that 75% of the sample was using hypnosis to some extent. The respondents reported using hypnosis for a wide range of physical, emotional, and habit problems. The most common hypnosis techniques applied were symptom removal via direct or indirect suggestions, and hypnosis complications were both minor in nature and rare.

Three Australian surveys were conducted in the 1970s and 1980s among the membership of the Australian Society for Clinical and Experimental Hypnosis about their practices and experiences (Channon, 1985; Sheehan & McConkey, 1979; Verbene 1976). With samples up to a couple of hundred respondents and consisting of a mix of physicians, psychologists and dentists, these surveys asked the clinicians a wide range of questions that varied from survey to survey, including what problems they treated, their therapy styles, the extent of their use of hypnosis, and perceived contraindications for hypnosis. The responses generally reflect treatment of anxiety,

psychosomatic problems, smoking and excess weight as top applications of hypnosis by the sampled clinicians. In the last of this survey series, Channon (1985) found that the most typical induction techniques used by the clinicians were eye fixation and systematic relaxation, and that the most common techniques employed in hypnotherapy were ego-boosting, imagery, and direct suggestions.

Kraft and Rodolfa (1981) examined hypnosis use among psychologists in the U.S. by surveying 298 general members of the American Psychological Association (APA), and 165 from the hypnosis division of the APA (Division 30). They assessed the extent of hypnosis use and most common therapeutic applications among respondents, in addition to their hypnosis training history, research interests, and attitudes toward hypnosis. Among the results, they reported that nearly half of the general APA members surveyed (47%) had some hypnosis training, and one-third had practiced hypnosis for a year or longer, whereas hypnosis training and use was, unsurprisingly, nearly universal in the Division 30 survey subset. Of nine predefined categories of clinical applications of hypnosis assessed, hypnosis users in both groups reported most use in five of these categories, with similar prevalence of use across all five of them: neurotic/anxiety, situational/adjustment, habit control, psychosomatic applications, and pain control. Survey respondents in both groups generally had favorable views of hypnosis and rated it predominantly as a useful and appropriate clinical technique, but these sentiments were more strongly expressed by the Division 30 subset.

All of these survey studies that have offered broad snapshots of hypnosis as it is generally applied in clinical practice are now too old (published 37-58 years ago) to be considered to have much direct bearing on present-day clinical hypnosis and are mostly of historic interest in the field. The current practices, experiences and perspectives of clinical hypnosis practitioners are

therefore largely unknown. Questions such as how effective different therapeutic applications with hypnosis are in the experience of clinicians, how frequently adverse events occur in hypnotherapy as it is practiced in the present era and what the nature and severity are of such events, how commonly different hypnosis techniques are applied, what other therapy modalities are used alongside hypnosis, and what practicing hypnotherapists perceive as the factors that produce success in clinical hypnosis, remain unaddressed by the recent literature. These are important topics for understanding the value, impact and characteristics of hypnosis as a current clinical treatment modality.

In 2018, The Society for Clinical and Experimental Hypnosis established a Task Force for Efficacy Standards in Hypnosis Research (the Task Force), composed of the ten hypnosis researchers and clinicians from seven countries who are the authors of this paper. The mission of the Task Force is to develop formal efficacy standards for outcome research in hypnosis, and to formulate a set of recommendations to further best practices for hypnosis research.

In the process of our Task Force work, we decided that it would be important to align the recommendations and standards that we are formulating with current practices, needs and outlook in the field of clinical and experimental hypnosis. As it was apparent that no comprehensive information existed pertaining to contemporary practices and views in these communities, the Task Force resolved to conduct a new large international survey of clinical hypnosis professionals to obtain this information for guidance in its work, while simultaneously providing the field of hypnosis in general with broad information regarding the practices and perspectives of hypnosis practitioners. The survey combined inquiry about clinical practice and research in hypnosis, as hypnosis researchers and clinicians are overlapping groups. Only the information collected from participants who were clinicians is presented in this current paper.

The survey findings regarding hypnosis research, which we consider a separate sub-study, will be summarized in a different paper.

Aims

The aims of this survey study were to examine and document current practices, experiences and perspectives of hypnosis clinicians, including:

- a. Prevalence of use of different hypnosis approaches and techniques;
- b. Extent of use of hypnosis, and what therapeutic methods are commonly utilized alongside hypnosis;
- c. Extent of use of teletherapy for hypnosis treatment;
- d. Perceived effectiveness of specific hypnosis applications common in the field, based on the clinicians' own experience;
- e. Prevalence and nature of adverse effects of hypnosis treatment;
- f. Factors deemed important for success in clinical hypnosis and for engendering the phenomenon of hypnosis; and
- g. Outlook on future use of clinical hypnosis in society.

Methods

Participants.

The survey was targeted toward hypnosis clinicians and/or researchers in any country. With a view toward obtaining a breadth of responses from the field, we set ourselves initial goals

for both sample size and international scope: Obtaining responses from at least 250 clinicians and 100 researchers, with responses from as many countries as possible by enlisting the help of international hypnosis societies (see below).

Materials.

A copy of the entire survey questionnaire used in the study is publicly available as a PDF format document on the Open Science Framework site of this survey project, at this link:

<https://osf.io/djcm5/>

The survey consisted of questions about the following:

1. *Participant basic demographics:* Age, sex, and country of residence.
2. *Participant professional characteristics:*
 - a. Profession
 - b. Highest academic degree attained
 - c. Number of years in clinical practice
 - d. Number of years using clinical hypnosis
 - e. Type(s) of clinical practice setting
 - f. Roles in clinical hypnosis (in addition to clinical services, these could involve hypnosis research, academic teaching about hypnosis, and hypnosis training)
 - g. Percent of all therapy sessions and percent of all clients, respectively, where hypnosis is used
 - h. Distribution of age groups typically treated by the clinician: i.e., the percent who are children < 13 years old, adolescents 13-17 years, adults 18-64 years and adults 65 years and older, respectively.

3. *Techniques or therapy modalities other than hypnosis used by the clinician in treatment.* The response format was a checklist of 16 different options (e.g., cognitive therapy, eye movement desensitization and reprocessing (EMDR), or medication), plus options for three free-text fill-in answers or for indicating “None - I exclusively use hypnosis for therapy.”
4. *Hypnosis approaches the clinician uses commonly.* This question included 6 pre-set response options – Ericksonian (Short, 2021), traditional hypnosis, cognitive hypnotherapy, hypnotic relaxation therapy (Elkins, 2014), psychodynamic or psychoanalytic hypnotherapy, and evidence-based practice of hypnotherapy - as well as free-form write-in boxes for other approaches used but not listed. Respondents were asked to check all responses that applied to them.
5. *Hypnosis techniques used regularly by the clinician in treatment.* The response format was a checklist of 10 options: affect bridge, age regression, dissociation, age progression, progressive relaxation, visualization of desired outcomes, metaphors, mental imagery, indirect therapeutic suggestions, and direct therapeutic suggestions.
6. *Assessment of hypnotizability.* The respondents were asked whether they used methods to measure hypnotizability in their clients (yes/no) and if so, what methods they generally use for that purpose.
7. *Where the clinician received hypnosis training.* This was a checklist with names of different major hypnosis societies as options, as well as “self-study” and “University course or academic program,” “workshops or courses not affiliated with any hypnosis organization” and a fill-in free-text box for additional training sources.

8. *Perceived relative effectiveness of clinical applications.* The respondents were asked to rate each of 24 different commonly used clinical applications of hypnosis in regard to their effectiveness based on their own personal experience. The five response options were: “not effective,” “minimally effective,” “moderately effective,” “highly effective,” and “cannot judge - not enough experience.”
9. *Adverse effects associated with hypnosis.* The respondents were asked to indicate, by providing three separate percentages, what percent of their hypnotherapy clients have any kinds of adverse (negative) effects associated with hypnosis, serious adverse effects they believed might have harmed their clients’ physical health, and serious adverse effects that might have harmed the clients’ mental health. If they reported encountering adverse effects at all, they were also asked to report the typical duration of these, by distributing percentages of total occasions between “a few minutes,” “an hour or longer,” and “a day or longer,” respectively, in a way that added up to 100 percent. They were furthermore asked to indicate on a checklist of 12 different types of possible hypnosis-associated adverse effects -- such as emotional upset, headache or difficulty terminating hypnosis -- which ones they had ever observed in their clients. Additionally, the respondents were given the option to write in other types of hypnosis-related adverse effects they had encountered than those provided in the checklist.
10. *Client factors perceived to be important for success in clinical hypnosis.* Respondents selected from the options “not at all important,” “a little important,” “moderately important,” “very important,” or “extremely important” to indicate how important they

believed each of ten client factors such as motivation or hypnotizability are for a successful clinical hypnosis intervention.

11. *Factors perceived as important for creating the phenomenon of hypnosis.* On the same 5-point scale from “not at all important” to “extremely important” as for rating factors for successful clinical hypnosis, the respondents were asked to rate 16 client factors in regard to their importance for successfully producing the phenomenon of hypnosis (but not necessarily for treatment efficacy of hypnosis). Note: The term hypnosis was not defined for the participants in this question or other questions in the survey.
12. *Use of teletherapy and its perceived effectiveness.* The respondents were asked whether they conduct hypnosis treatments via video conferencing and telephone, respectively, in separate questions, with response options of “never,” “rarely,” “sometimes,” “often,” or “most times or always.” If they reported any use of each of these teletherapy methods, the survey automatically followed up with two additional questions, assessing how effective they perceived the respective method of treatment delivery to be, and whether they had first started using that form of teletherapy after the beginning of the COVID-19 pandemic.
13. *Perception of the future of clinical hypnosis.* A single question assessed how widely the respondents thought clinical hypnosis would be practiced ten years in the future, with the five response options being “much more widely used in clinical practice than now,” “a little more widely used in clinical practice than now,” “about as widely used in clinical practice as it is now,” “a little less widely used in clinical practice than now,” and “much less widely used in clinical practice than now.”

14. Questions related to hypnosis research. The survey also contained questions related to hypnosis research, such as about research priorities in the field of hypnosis and important factors for conducting high-quality hypnosis research. Results from the responses to these questions will be reported in a separate paper.

Procedure

The online survey used in this study was hosted and managed by the first author (Palsson), using Qualtrics XM software (Qualtrics, LLC. Provo, Utah) under an institutional license at the University of North Carolina at Chapel Hill. After providing informed consent online, participants proceeded directly to the survey questions. The survey data collection was conducted from November of 2020 to the end of February of 2021. To protect the personal privacy of the survey participants and encourage frank responses, the survey was conducted in a completely de-identified manner: No unique personal identifiers for the survey participants were associated with their responses in the survey database, and this was explained in the consent form. Moreover, only minimal personal information (age and sex, profession, highest academic degree, and number of years in clinical practice) was collected, to reduce the probability of indirect identification of participants via the pattern of data they provided. The study investigators were unable to determine the identity of respondents in the dataset.

Multiple different methods were used to recruit participants for the survey. The Task Force contacted several of the world's largest hypnosis societies and obtained co-sponsorship for the project from the Society for Clinical and Experimental Hypnosis, the American Society of Clinical Hypnosis and its component societies, the International Society of Hypnosis, the European Society of Hypnosis, the American Psychological Association's Division 30 (Society

of Psychological Hypnosis), the Italian Society of Hypnosis, and the British Society of Clinical and Academic Hypnosis. These societies advertised the survey to their members and encouraged them to participate through e-mails and announcements in their newsletters.

The Task Force members assembled a collective contact list of hypnosis colleagues for whom they had e-mail contact information, resulting in more than eight hundred e-mail addresses, and these were used for direct e-mail invitations to participate. The popular hypnosis listserv shared by several of the hypnosis societies, and social media, were used to further highlight the study and ask practitioners to complete the survey.

In an effort to increase international participation beyond English-speakers, the English version of the survey was translated by native-speaker hypnosis professionals (including two of the authors, De Benedittis and Kekecs) into three additional languages: Italian, Hungarian, and French. Members of the national hypnosis societies in the corresponding countries, Italy, France and Hungary, were invited via e-mail to complete the survey in their own language.

The survey study was reviewed by the Biomedical Institutional Review Board (IRB) of the University of North Carolina at Chapel Hill prior to data collection and deemed exempt from IRB oversight due to the anonymous nature of the survey.

Data Analysis

Data were analyzed with IBM SPSS 28.0 Statistics for Windows software (IBM Corp. Armonk, NY). Data analyses were predominantly descriptive, as no specific hypotheses had been pre-specified. Results were summarized as means with standard deviations for continuous variables and frequencies and percent for ordinal and categorical responses, respectively.

Results

Survey sample size and demographic characteristics

Of a total of 791 hypnosis clinicians who completed consent and started the survey, 691 finished the survey (87.4% completion rate). Data from completers was used in the analyses results presented below.

The mean age of the final sample of 691 survey completers was 59.7 years ($SD=12.5$). The sample included 53.4% females, 46.5% males, and one person (0.1%) who reported “other” for sex.

The U.S. was the most represented country in the survey, being home to more than half of the survey respondents (56.3%). Other countries with a substantial number of participants were France (14.0%), Italy (8.0%), and the UK (4.8%). Hungary, Australia, Canada, Israel and Germany each constituted about one to two percent of the sample respondents, whereas the remaining 23 countries with participants in the study each represented less than one percent of the total sample (see Table 1 for details). Apart from the U.S., nearly all participants were from European countries (Russia and Turkey were counted as European for this purpose), with only 14 respondents (2.0% of the sample) outside of either Europe or the U.S.

Table 1*Number and percentage of survey respondents by country (N=691)*

Country:	Number (%) of respondents
USA	389 (56.4%)
France	97 (14.0%)
Italy	55 (8.0%)
UK	33 (4.8%)
Hungary	16 (2.3%)
Australia	14 (2.0%)
Canada	12 (1.7%)
Israel	12 (1.7%)
Germany	11 (1.6%)
Sweden	6 (0.9%)
Denmark	5 (0.7%)
Spain	5 (0.7%)
Mexico	4 (0.6%)
Turkey	4 (0.6%)
Ireland	3 (0.4%)
Switzerland	3 (0.4%)
Austria	2 (0.3%)
Belgium	2 (0.3%)
Costa Rica	2 (0.3%)
Japan	2 (0.3%)
Netherlands	2 (0.3%)
New Zealand	2 (0.3%)
Norway	2 (0.3%)
India	1 (0.1%)
Iran	1 (0.1%)
Malaysia	1 (0.1%)
Portugal	1 (0.1%)
Puerto Rico	1 (0.1%)
Russia	1 (0.1%)
Serbia	1 (0.1%)
Ukraine	1 (0.1%)

Professional characteristics

The four professional categories that survey participants endorsed most commonly to describe their profession were clinical psychologist (42.7%), hypnotherapist (24.0%), physician (19.1%), and social worker (10.0%); they could select multiple options from a pre-set checklist,

or write in others that they believed were better suited to describe their profession (see Table 2). By far, the most common type of practice setting where the surveyed clinicians worked was a solo mental health practice (60.5%), with no other type of setting reported by more than 15% of respondents.

On average, the participants had been in clinical practice for 26.8 years ($SD=13.0$; range <1 to 63 years) and had practiced hypnosis for an average of 16.9 years ($SD=13.0$; range <1 to 53 years). In addition to their clinical work in hypnosis, 14.2% of the participants indicated that they are also hypnosis researchers, 15.6% reported that they engage in academic teaching about hypnosis, and 29.8% indicated that they train professionals in hypnosis. More than half (55.4%) of the sample possessed a doctoral degree, 33.3% a master's degree, and less than 6% had either bachelor's degree as their highest academic degree or no degree. Further details about the distribution of these professional characteristics of the survey sample are provided in Table 2.

Table 2

Professional characteristics of participants (multiple response options could be selected for profession and practice setting) (N=691)

Characteristic	Number (%)
<i>Profession</i>	
Clinical psychologist	295 (42.7%)
Hypnotherapist	166 (24.0%)
Physician	132 (19.1%)
Social worker	69 (10.0%)
Professional counselors	40 (5.8%)
Nurse	28 (4.1%)
Dentist	19 (2.7%)
Graduate student (field specified)	19 (2.7%)
Nurse practitioner	16 (2.3%)
Marital and family therapists (LMFT)	16 (2.3%)
Psychotherapist	14 (2.0%)
Experimental psychologist	13 (1.9%)
Nurse anesthetist	11 (1.6%)
Neuroscientist	8 (1.2%)
Other professions (specified)	80 (11.6%)
<i>Education (highest academic degree):</i>	
Doctoral degree	383 (55.4%)
Master's degree	229 (33.1%)
Bachelor's degree	40 (5.8%)
Other degree	26 (3.8%)
Graduate student	7 (1.0%)
No academic degree	6 (0.9%)
<i>Practice settings:</i>	
Solo mental health or psychology practice	418 (60.5%)
Medical specialty clinic	101 (14.6%)
Mental health or psychology group practice	96 (13.9%)
Hospital inpatient setting	94 (13.6%)
Solo private medical practice	75 (10.9%)
Interdisciplinary health clinic	70 (10.1%)
University counseling center	15 (2.2%)
Other (specified)	83 (12.0%)

Extent of use of hypnosis with clients, and age groups treated.

As can be seen from the distribution of responses in Table 3, the surveyed clinicians generally did not use hypnosis with nearly all clients or in nearly all therapy sessions. Two-thirds (67.7%) reported using hypnosis with half or less of all therapy sessions, and similarly, 62.1% reported using hypnosis with half or less of all their clients.

Only twelve therapists in the total sample (1.8%) reported that their practice of hypnotherapy was exclusively conducted with children or adolescents under age 18, whereas the majority of survey respondents (57.6%) indicated that they treated some mix of minors and adults, and the remaining 40.2% only adults. Seven survey participants did not provide interpretable data on the age group distribution of their clients.

Table 3

Extent of use of hypnosis by clinicians in the survey (N=691). The table provides distributions of the estimates by survey respondents of the percentage of all therapy sessions in which they use hypnosis (left), and of the percentage of all their clients with whom they use hypnosis (right).

Percentage of all <u>sessions</u> that involve hypnosis:	Number (%) of therapists	Percentage of all <u>clients</u> with whom hypnosis is used	Number (%) of therapists
10% or less	161 (23.3%)	10% or less	139 (20.1%)
20%	102 (14.8%)	20%	82 (11.9%)
30%	91 (13.2%)	30%	80 (11.6%)
40%	51 (7.4%)	40%	42 (6.1%)
50%	62 (9.0%)	50%	86 (12.4%)
60%	41 (5.9%)	60%	35 (5.1%)
70%	52 (7.5%)	70%	50 (7.2%)
80%	48 (6.9%)	80%	56 (8.1%)
90%	42 (6.1%)	90%	64 (9.3%)
100%	41 (5.9%)	100%	57 (8.2%)

Therapy modalities used beside hypnosis.

Almost all of the survey respondents indicated that they used other therapy modalities or techniques in addition to hypnosis – only 3.8% said they used hypnotherapy exclusively. Most prevalent among these other interventions were psychotherapy (unspecified), cognitive therapy, relaxation training, behavioral intervention, and mindfulness meditation, all of which were reported to be used by more than forty percent of the respondents (see Table 4).

Table 4

Therapeutic techniques/modalities other than hypnosis used by survey respondents (N=691)

Therapy technique/modality	Number (%) of respondents:
Psychotherapy	469 (67.7%)
Cognitive therapy	400 (57.7%)
Relaxation training	361 (52.1%)
Behavioral intervention	290 (41.8%)
Mindfulness meditation	285 (41.1%)
Psychodynamic or insight-oriented therapy	253 (36.5%)
Marital/family therapy	211 (30.4%)
EMDR	175 (25.3%)
Meditation techniques other than mindfulness	158 (22.8%)
Multi-disciplinary treatment	127 (18.3%)
Typical medical care	118 (17.0%)
Medications	101 (14.6%)
Behavioral medicine	93 (13.4%)
Diet intervention	75 (10.8%)
Biofeedback	74 (10.7%)
Physical therapy	34 (4.9%)
None - I exclusively use hypnosis for therapy	26 (3.8%)
Typical dental care	23 (3.3%)
Neuromodulatory treatment	13 (1.9%)

Hypnotherapy approaches and techniques used by survey respondents.

Among the six options offered to indicate what hypnosis approaches the respondents used, the most commonly endorsed was the Ericksonian approach (70.6%), but hypnotic relaxation therapy and traditional hypnosis were also used by around half of the sample (55.3% and 49.9%, respectively; see Table 5). No self-reported hypnosis approach was reported by 1% or more of the sample in the free-text fill-in option for this question, except for ego state therapy (1.0%).

Table 5

Hypnosis approaches that survey respondents reported using commonly (N=691).

Multiple options could be selected

<u>Hypnosis approach:</u>	<u>Number (%):</u>
Ericksonian	488 (70.6%)
Hypnotic relaxation therapy	382 (55.3%)
Traditional hypnosis	347 (49.9%)
Cognitive hypnotherapy	233 (33.7%)
Evidence-based practice of hypnotherapy	206 (29.8%)
Psychodynamic or psychoanalytic hypnotherapy	155 (22.4%)
Other (specified)	69 (10.0%)

When asked to indicate on a ten-item checklist which hypnosis techniques they regularly use, large proportions of the therapists endorsed each of the ten options (Table 6). Mental imagery, metaphors, indirect suggestions, progressive relaxation, visualization of desired outcomes and direct suggestions were all endorsed by about eight out of ten therapists as regularly used (86.3% to 77.9%), suggesting that these are routine components of hypnotherapy in clinical hypnosis practice.

Table 6*Hypnosis techniques used regularly by survey respondents (N=691)*

Technique:	Number (%) of respondents:
Mental imagery	596 (86.3%)
Metaphors	592 (85.7%)
Indirect therapeutic suggestions	577 (83.5%)
Progressive relaxation	552 (79.9%)
Visualization of desired outcomes	551 (79.8%)
Direct therapeutic suggestions	540 (77.9%)
Dissociation	436 (63.1%)
Age regression	338 (48.9%)
Age progression	320 (46.3%)
Affect bridge	319 (46.2%)

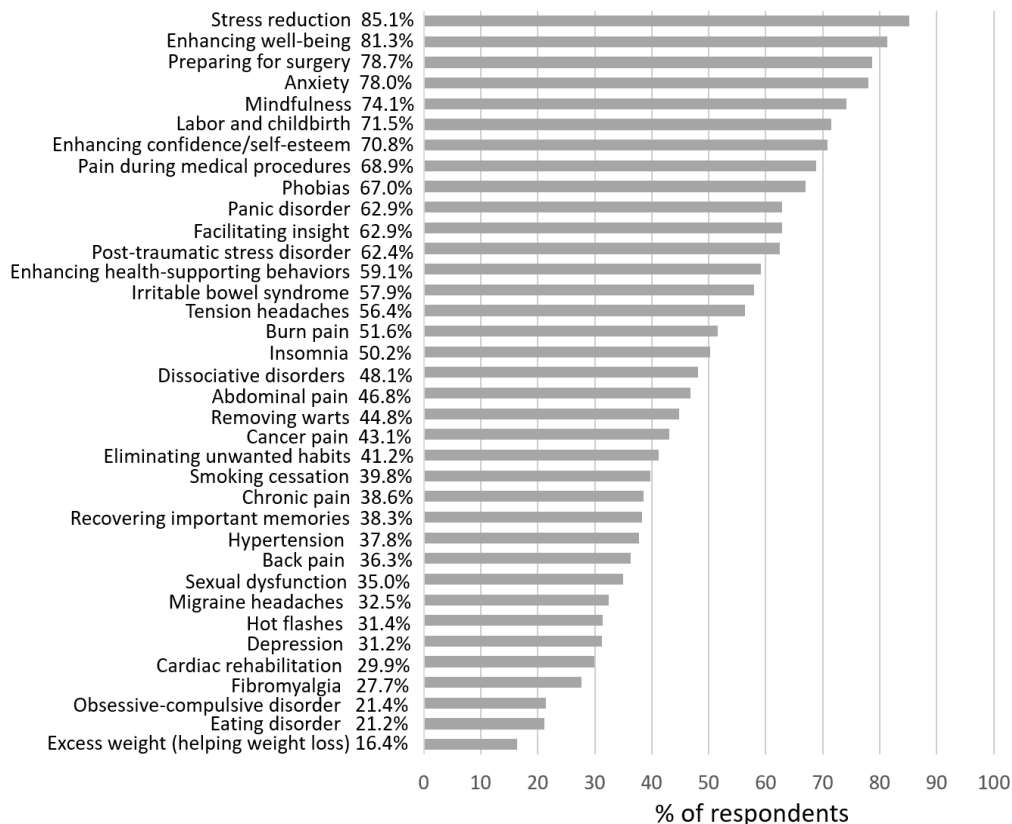
Relative effectiveness of common clinical hypnosis applications.

We asked the survey respondents to rate the effectiveness of a range of specific clinical hypnosis applications if they believed they had sufficient personal clinical experience to make such judgement. They rated these applications on a four-point scale from “not effective” to “highly effective.” If they did not have sufficient personal experience with a particular application, the respondents did not rate it, but instead used a “cannot judge - not enough experience” response option. The 24 hypnosis applications listed for this purpose were selected by the authors to represent a wide selection of common therapeutic uses. To assess the collective judgment of the clinicians of effectiveness, we calculated the percentage of all therapists providing ratings (i.e., those with enough experience with the application in question) who rated each application as highly effective. As can be seen in Figure 1, the specific applications that were rated as highly effective by the most clinicians, i.e., by 70% or more, based on their own clinical experience were stress reduction, wellbeing-enhancement, preparations for surgery, anxiety treatment, mindfulness application, labor and childbirth uses, and enhancing self-esteem and confidence. Conversely, the hypnosis applications least commonly rated as highly effective

were those for weight loss, eating disorders, obsessive-compulsive disorder, fibromyalgia, and cardiac rehabilitation. Each of those applications received high effectiveness rating from less than 30% of clinicians who had experience with them. It should be noted that when clinicians failed to give a particular application a “highly effective” rating, that did not necessarily mean they thought it was ineffective. Many gave instead the lower rating of “moderately effective,” presumably reflecting some perceived therapeutic benefit. However, we believe that focusing on high effectiveness ratings as we do in Figure 1 provides a clear indicator of the overall perceived success of the particular applications among the hypnosis clinicians and offers a simple way to compare and contrast the clinician-perceived relative utility of hypnosis across different uses.

Figure 1

Percentage of survey respondents rating each application of hypnosis as highly effective based on their own experience (N=691). Ratings were only made by clinicians who deemed themselves to possess enough experience with the specific applications to rate them



Negative effects associated with hypnosis treatment.

To assess the extent to which hypnosis clinicians encounter adverse (negative) effects associated with hypnosis treatment, the survey participants were asked to estimate the percentage of all their hypnotherapy clients who had any such adverse effects. They were also asked what percentage of their clients had serious adverse effects that they thought might have harmed their client's mental or physical health, respectively, and which types of specific adverse effects they had seen in their clients. The results are summarized in Table 7.

Nearly half of the clinicians (44.7%) stated that 0% of their clients had experienced any adverse effects related to hypnosis. The 55.3% who had seen adverse effects in their clients mostly estimated them as having occurred in only 1% of clients (20.4% of respondents) or in

2-5% of clients (24.2%). Only 10.7% of all the clinicians surveyed estimated that more than five percent of their clients had adverse effects to hypnosis.

Only a small minority of the clinicians (11.3%) reported having encountered serious adverse hypnosis-related effects in any of their clients. That percentage was similar for mental health professionals (10.5%) and medical professionals (12.9%). Serious adverse effects that the respondents believed might have harmed their clients' mental health were reported by 10.1% of all respondents, and the corresponding percentage was 5.5% for serious adverse effects that might have harmed the clients' physical health. Both these categories of serious negative effects were estimated by the majority of clinicians reporting them to have happened to just one percent of all their clients.

Adverse effects of any kind observed in clients were predominantly estimated by the respondents to be brief. Averaged across the 55.3% of clinicians who reported any adverse effects, they were estimated to have lasted a few minutes on 65.6% (95% CI: 61.5%-69.7%) of occasions, an hour or longer on 14.3% (11.8%-16.8%) of occasions, and a day or more on 6.5% (4.6%-8.4%) of occasions.

Table 7

Frequency of adverse hypnosis-related effects reported by the survey respondents (N=691)

Percent of all clients:	<u>Any</u> adverse hypnosis-related effects:	<u>Serious</u> adverse hypnosis-related effects that might have harmed client's <u>mental</u> health:	<u>Serious</u> adverse hypnosis-related effects that might have harmed client's <u>physical</u> health:
0%	309 (44.7%)	621 (89.9%)	653 (94.5%)
1%	141 (20.4%)	40 (5.8%)	20 (2.9%)
2-5%	167 (24.2%)	14 (2.0%)	7 (1.0%)
6-10%	55 (8.0%)	11 (1.6%)	7 (1.0%)
>10%	19 (2.7%)	2 (0.3%)	1 (0.1%)

Survey respondents were asked to indicate different specific types of adverse hypnosis-related effects that they *ever encountered* in a checklist. As seen in Table 8, emotional upset was the most common, endorsed by 41.7% of all respondents, but disorientation, drowsiness, unwanted access to traumatic memories, and difficulty re-alerting a client were also reported by more than one in every five respondents.

Table 8

Specific types of adverse hypnosis-related effects reported to have been encountered by survey respondents (N=691)

Type of adverse hypnosis-related effect:	Number (%) of clinicians reporting having ever encountered this:
Emotional upset	288 (41.7%)
Disorientation after hypnosis	178 (25.8%)
Drowsiness	155 (22.4%)
Unwanted access to traumatic memories	146 (21.1%)
Difficulty terminating/waking from hypnosis	138 (20.0%)
Headache	101 (15.0%)
Confusion after hypnosis	99 (14.3%)
Unwanted dreams or nightmares	52 (7.5%)
Nausea	39 (5.6%)
Sensory or motor disturbance	38 (5.5%)
Involuntary jolts or spasms (myoclonic jerks)	19 (2.7%)
Stiff muscles	14 (2.0%)

Factors perceived as important for producing success in hypnosis treatment.

To gain a picture of the collective perception of what clinicians see as the most important client factors for producing success in hypnosis treatment, we asked them to rate the importance of ten potential factors often discussed in the hypnosis literature. As can be seen in Table 9, we found that rapport or a positive relationship with the therapist, motivation, readiness for change, and expectation of benefit were the top determinants rated as very or extremely important in clinicians' collective perception, with rapport given the designation of high importance by the most respondents by far (87%). Conversely, of the ten factors evaluated, hypnotizability was least often rated as very or extremely important (26.6%).

Table 9

*Percentage of clinicians rating different client factors as either very important or extremely are
“for the therapeutic success of clinical hypnosis treatment” (N=691)*

Client factor:	% very or extremely important ratings:
Rapport or positive relationship with therapist	87.0%
Motivation	75.4%
Stage of change/readiness to change	69.9%
Expectancy of benefit	59.6%
Attitude toward hypnosis	47.9%
Absorption ability	46.0%
Capacity for mental imagery	39.7%
Locus of control	31.3%
Ability to relax	34.7%
Hypnotizability	26.6%

Factors perceived as important for producing the phenomenon of hypnosis

To examine the perspectives of clinicians regarding the factors that facilitate hypnosis, independent of therapeutic utility, we asked them to rate sixteen client factors often discussed in the empirical and clinical literature as relevant to hypnosis. As can be seen in Table 10, we found that as in the case of therapeutic success determinants, rapport was rated as very or extremely important by the most therapists (88.4%) and motivation was also highly rated in that regard. However, narrowing the focus of attention in this case rivaled those two factors in perceived importance by the clinicians, being rated as very or extremely important by 81.6% of them for producing the phenomenon of hypnosis.

Table 10

Percent of clinicians rating different client factors as either very important or extremely for “successfully producing the phenomenon of hypnosis (but not necessarily for treatment efficacy of hypnosis)” (N=691)

Client factor:	% very or extremely important ratings
Rapport of hypnotized person with therapist	88.4%
Narrowing of the focus of attention	81.6%
Motivation	75.3%
Turning the attention inward	63.2%
Expectancy	58.5%
Openness to new experiences	56.3%
Mental relaxation	55.4%
Positive attitude toward hypnosis	51.7%
Physical relaxation	48.6%
Dissociation from the here-and-now	47.6%
Suggestibility	42.5%
Automaticity/involuntariness (letting go of active control)	38.4%
Capacity for mental imagery	37.7%
Belief in hypnosis	31.5%
Hypnotizability	24.3%
Social compliance	22.9%

Assessment of hypnotizability.

Most clinicians in the survey (79.2%) stated that they do not measure the hypnotizability of their clients/patients. Among the 20.8% (n=144) who reported using such assessment, the most common methods specified were the Stanford Hypnotic Clinical Scale (Morgan and Hilgard, 1978), the Hypnotic Induction Profile, (Stern, Spiegel and Nee, 1978), and the Spiegel Eye Roll Test (Stern, Spiegel and Nee, 1978); mentioned by 19.4%, 12.5%, and 10%, respectively, of all respondents who measure hypnotizability.

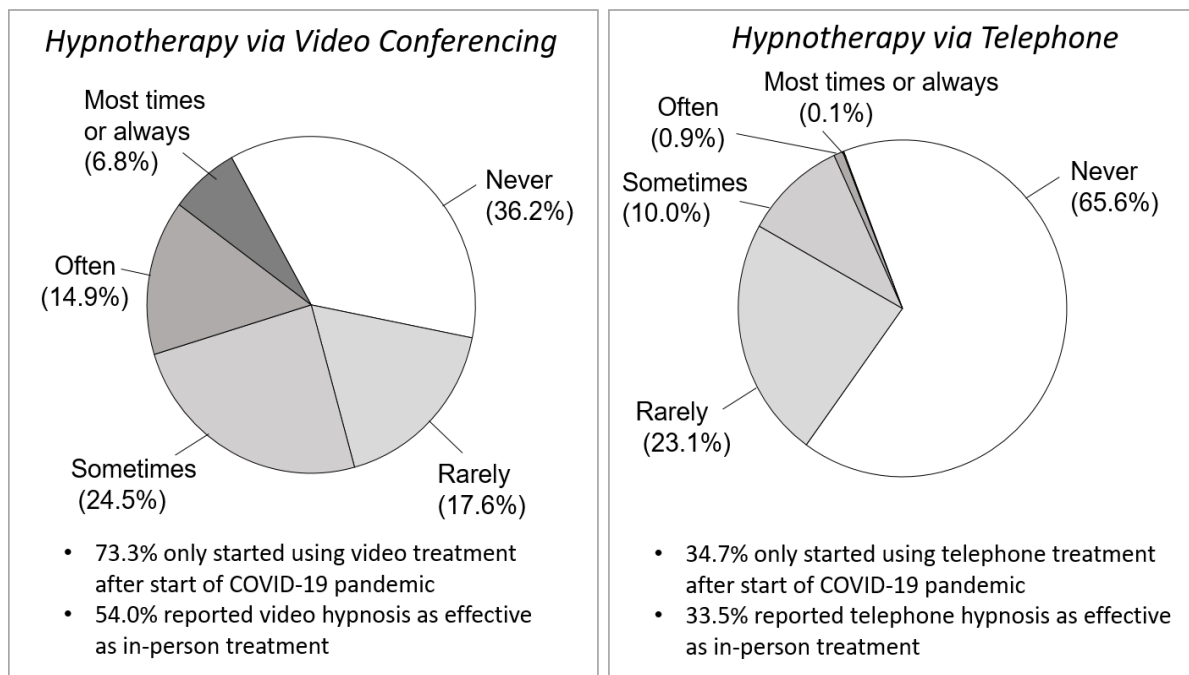
Experience with hypnosis treatment via teletherapy.

Nearly two-thirds of the respondents (63.8%) stated that they used video conferencing to deliver hypnosis treatment, and approximately one in five used it often or most or all of the time (see Figure 2). For the great majority of those who used hypnotherapy via video, this teletherapy approach was very recent, having only started after the onset of the COVID-19 pandemic (73.3%); meaning that they had been doing it for less than one year. Among those using this form of remote therapy, 54% stated that hypnosis delivered remotely via video was as effective as in-person therapy.

Hypnosis treatment via telephone was a less commonly utilized form of teletherapy by the survey participants, practiced by 34.4% of the respondents, and most of those who engaged in such telephone hypnosis used it rarely. Compared to video hypnotherapy, fewer respondents using telephone treatment had started it only after the onset of the COVID-19, and fewer (33.4%) deemed telephone hypnotherapy to be as effective as in-person treatment.

Figure 2

Summary of responses from all the clinicians surveyed about their experience with delivering hypnosis treatment delivered remotely via video conferencing or telephone (N=691)



Future prospects of hypnosis.

To gain a glimpse of the collective sense by this sample of hypnosis clinician of the future prospects of clinical hypnosis as a therapeutic modality in society, we asked them to rate how widely they thought clinical hypnosis would be used in ten years' time. The great majority indicated that they thought it would be used more widely at that time than now, either much more (38.6%) or a little more (37.6%), whereas 19.4% opined that it would be used about as widely as now, and only small fractions thought it would be used a little less (2.7%) or much less widely (1.4%) than today. Medical professionals were overall more optimistic than mental health professionals about increased use of hypnosis in 10 years, with nearly half of them, or 47.7%,

anticipating much wider use in a decade's time, compared to 34.4% of the mental health professionals.

Discussion

The survey presented here is the largest survey ever conducted on the practices and views of therapists in the field of clinical hypnosis, and the only one that has substantially included participants from many different countries. With the experiences and perspectives of 691 clinicians in our field represented, and participation by individuals in many mental health and medical clinical domains in a wide variety of practice settings, we believe these survey findings provide a highly informative summary picture of current clinical hypnosis practice and perspectives.

The survey provides valuable information in several areas, that is likely to be useful for the field of clinical hypnosis. Perhaps the three most unique aspects of our results are the effectiveness ratings across a wide range of common clinical hypnosis applications based on the clinicians' own experience, the documentation of teletherapy uses of hypnosis, and a more comprehensive picture of the extent of adverse events associated with hypnosis in clinical practice than previously available.

The ratings of perceived effectiveness of 24 specific clinical applications of hypnosis in our survey offer a high-level "insider look" at how well hypnosis is perceived to work in practice in the joint experience of practicing hypnosis clinicians. Uses of hypnosis for different presenting problems are generally not compared against each other in regard to their comparative effectiveness, so this aspect of our results produced a novel comparative picture with results that might be somewhat surprising to many in our field. It is notable, in particular, that some common

hypnosis applications like treatment of depression, eating disorders, and excessive weight were only rated as highly effective by less than a third of all the survey respondents who had experience with them, landing them close to the bottom of the relative perceived effectiveness hierarchy illustrated in Figure 1. However, it must be kept in mind that such comparatively low perceived effectiveness may not indicate inadequacy of hypnosis, specifically, as a treatment tool for these problems, but might instead reflect the difficulty of treating these particular presenting problems more generally. On the other hand, the upper end of the perceived effectiveness scale is likely to highlight some of the best clinical applications of hypnosis, where it dependably yields very good results for therapists. Based on our results, those top-performing clinical uses include stress reduction and wellbeing-enhancement, preparations for surgery, mindfulness and anxiety reduction uses, aiding of labor and childbirth, and enhancing of self-esteem and confidence.

The extent and nature of adverse events associated with hypnosis as applied in clinical practice are important to document (De Benedittis, 2009). In the clinical context, hypnosis is generally considered to be a safe psychological intervention with minimal side effects, and this is supported by recent systematic reviews of randomized clinical trials for treatment of medical problems (Schaefer et al, 2014; Häuser et al, 2016). However, comprehensive assessments of the frequency and severity of adverse events associated with hypnosis in the experience of hypnosis clinicians in general are now several decades old, and past reports have been limited in detail and lacking in generalizability due to the narrow scope of the sampling (single hypnosis societies or particular professions). Our survey data in this regard therefore both update the literature and add detail to the adverse effects picture of clinical hypnosis. Our findings are generally consistent with older conclusions from clinician surveys: As documented in the past by other researchers, a subset of practicing hypnosis clinicians does encounter adverse events to

some extent, but those effects are most often non-serious and short-lived (Levitt & Hershman, 1963; Pulver & Pulver, 1975). We also found, consistent with prior work (Levitt & Hershman, 1963), that the most common adverse side effect of hypnosis reported by clinicians is negative affect.

By venturing further in our questions than prior surveys, we did discover that a small subset of therapists has observed adverse effects that they consider serious enough that they might have harmed the physical or mental health of their clients. These are fortunately rare, but they call for additional research to gain understanding of their nature and risk factors, and especially which types of hypnosis-related techniques and suggestions are prone to evoking negative reactions or unwanted side effect, and how best to avoid these.

All in all, our survey findings regarding adverse effects support the view that clinical hypnosis is a very safe form of treatment. It is notable that nearly half (45%) of this large sample of clinicians reported that they do not encounter negative effects with any of their patients, and only one in ten of them (11%) had observed adverse effect that they believed could have been serious for their clients' physical or mental health. Since these clinicians had typically treated large numbers of clients in their career, having practiced clinical hypnosis for 17 years on average, it is clear that the incidence of adverse effects of any kind associated with clinical hypnosis is very low, and that serious ones are extremely rare. Moreover, when adverse effects occur, our findings indicate that they are in the majority of cases (66% of occasions by average estimate) very transient, lasting no more than a few minutes.

Finally, it is important to consider our findings on adverse effects of clinical hypnosis in the broader context of psychological interventions in general. It is likely that all psychological

therapies are associated with occasional negative effects, but this has been poorly documented in research to date (Duggan et al, 2014; Palermo et al, 2020). Recent studies on CBT and mindfulness meditation training have, however, found high prevalence of adverse effects to be associated with those particular interventions. A study (Schermuly-Haupt et al., 2018) using interviews with 100 CBT therapists about their most recent client who had completed therapy found that 43% of the clients had experienced unwanted negative effects during treatment, and 21% of them had serious or very serious CBT-related adverse effects. A study by Britton et al. (2021) of 96 completers of a mindfulness meditation training program and found that 58% of the program participants had experienced meditation-related unpleasant or negative effects, and 37% of these adverse effects impacted the functioning of the participants. A total of 14% of the participants had adverse effects that lasted longer than one day. Baer and colleagues (2021) similarly surveyed 84 schoolteachers and 74 university students who completed a mindfulness course and found that about two-thirds of the participants reported negative effects associated with the mindfulness course and 3-7% of them stated that they had suffered harm from the course. In comparison to these findings for other psychological interventions, our data do not seem to indicate any excess risk of adverse effects associated with clinical hypnosis. However, this needs to be better evaluated in the future by using the same assessment methods of adverse effects across treatment modalities.

The safety of hypnosis has also been studied in the laboratory context, where there have been some reports of infrequent negative reactions to hypnosis (Cardeña & Terhune, 2009; Coe & Ryken, 1979; Hilgard, 1974), but these effects were mild and transient, with most being shorter than an hour. For example, Hilgard (1974) conducted a study with 120 participants and found that about 30% of the participants reported some kind of negative aftereffect after

participating in a hypnotizability test via either the Harvard group scale of hypnotic susceptibility (Shor & Orne, 1963) or the Stanford Hypnotic Susceptibility Scale, Form C (Weitzenhoffer & Hilgard, 1962), e.g. stiff arm, stiff neck, headache, dizziness, or nausea. Later, Coe et al. (1979) reported, based on a larger study, that the aftereffects of the Stanford Hypnotic Susceptibility Scale, Form C (Weitzenhoffer & Hilgard, 1962) were not significantly higher than in different control conditions, including participating in a non-hypnosis experiment and taking a university exam. A more recent report on a much larger sample of 642 undergraduate students indicated that roughly 2% of the participants who underwent hypnotizability assessment with the Waterloo-Stanford Group C Scale of Hypnotic Susceptibility (WSGC; Bowers, 1993) had some transient negative reactions (Cardeña & Terhune, 2009). Notably, most of these negative reactions were connected to the age regression item in the scale, bringing up negative memories from the past, so the authors recommended the omission of this item in the administration of the WSGC. This may indicate that certain hypnosis techniques (such as age regression) may result in more negative reactions than others. It might also explain why almost half of the clinicians in our survey reported never encountering negative effects of hypnosis, since they might be using hypnotic suggestions and techniques that are less prone to provoking these already rare negative events.

Delivery of clinical hypnosis intervention remotely via video or telephone is a topic that has not been previously covered in published clinician survey studies. Our survey was conducted during the height of the COVID-19 pandemic, just before vaccines became available, in a period when lockdowns and stringent disease precautions had largely prevented people from seeking non-emergency clinical services in most communities. Clinicians in many countries had been unable to treat their usual clientele in their clinics and offices, and our survey results show that

many turned to teletherapy, especially via video conferencing, to overcome these obstacles. Our survey clearly captured the dramatic and quick shift toward far greater use of remote delivery of hypnosis treatment. Nearly two-thirds of all the respondents reported having used hypnotherapy via video conferencing, and most of them (73%) had not used it at all before the pandemic started less than a year earlier. Many were using it at least sometimes in their practice. Importantly, more than half (54%) of all the clinicians in our sample who had used this form of delivery of hypnosis intervention reported it to be as effective as in-person treatment. It seems likely from these findings that the extensive and often positive experience of video hypnotherapy forced on practitioners by extraordinary circumstances in society will lead many clinicians to continue using this delivery mode after the end of the pandemic, thereby substantially changing the traditional nature of clinical hypnosis practice and facilitating wider access to hypnotherapy for many people who cannot access in-person treatment. In contrast, we found that telephone hypnotherapy is much less commonly used by the clinicians we surveyed, and also less likely to be found as effective as in-person treatment by those who have tried it.

Our survey results also offer an unprecedented glimpse of the perceptions of clinical hypnosis practitioners about the importance of different client factors for effective hypnosis and good therapeutic results. Those findings demonstrate that rapport between client and therapist is considered of great importance by nearly all clinicians. This highlights the importance of the theoretical models that emphasize the interactional nature of hypnosis (Bányai, 1991, Jensen et al, 2015). It also underscores the importance of investigating the possible mechanisms of the process of hypnosis from an interactional perspective – that is, to study the hypnotist-client dyad, rather than the client alone, on both phenomenological (Varga, 2013, Varga et al, 2009) and neurophysiological levels (Kasos et al, 2018; Varga and Kekecs, 2014). The results also showed

that other client factors considered of high importance in successful clinical hypnosis by the majority of practitioners include motivation, readiness to change, and expectancy. In contrast, it is noteworthy that hypnotizability was the factor least commonly rated as very or extremely important among all the client factors listed in our checklists, both in regard to producing successful therapeutic outcomes and for producing the phenomenon of hypnosis. Hence, it seems to be the predominant view of hypnosis practitioners that hypnotizability is of relatively little practical importance for the practice of clinical hypnosis. That sentiment is also reflected in the fact that four of every five of the survey participants do not to do any assessment of the hypnotizability of their clients.

Our survey study has multiple strengths, including the large sample size, multi-national composition, the wealth of information obtained from the clinicians about many different aspects of their practice and outlook, the good balance between the sexes, and the diversity of professions, types of clinical practice and clinical experience levels represented in our sample. All of this exceeded what has been done in previous similar surveys in our field and contributes to providing a uniquely comprehensive picture of current clinical hypnosis in practice.

A limitation in our study was the uneven participation in the survey across countries. Just over half of the sample was from the U.S. and almost all respondents were from Western countries. Conversely, Asian, African, and South American communities were under-represented. It will be necessary for future surveys within the clinical hypnosis community to more rigorously target these regions.

A further limitation of this study is that due to use of a multitude of recruitment methods, including social media, in order to ensure a large final sample, we are unable to estimate in any

way the overall participation rate among individuals who received invitations to participate or became aware of the survey. Where we used direct invitations via e-mail, the response rates were in the 15 to 20 percent range: This could be estimated in spite of the de-identified survey method, since the Qualtrics survey system we used reports survey completion percentages resulting from mass e-mail invitations. It is likely that the response rate was similar for the whole survey sample, but we do not have any way of knowing that with certainty. As only a fraction of clinicians who became aware of the survey via direct invitations, announcements, or social media postings chose to participate, it is possible that this produced some kind of bias in the sample of responses collected, but it is unclear in what particular ways it affected the results.

In conclusion, we believe that the survey results we have summarized here enhance the state of knowledge about current clinical hypnosis in society in many ways, helping to fill gaping holes in our understanding of the practice of clinical hypnosis. In addition, we hope that the information presented here will guide and encourage further research in the areas we focused on, including real-world effectiveness of different clinical applications of hypnosis, adverse effects, hypnosis teletherapy, and client factors that make hypnosis successful.

Data availability statement

The data that support the findings of this study are openly available on the Open Science Framework website at <https://osf.io/p7wbx/>.

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