Contemporary Hypnosis (2000)
Vol. 17, No. 3, pp. 117–126

THE ALLEGED DANGERS OF STAGE HYPNOSIS

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Introduction

From time to time, the safety of hypnosis and its possible misuse are subjected to attention in the learned literature and the mass media. In the UK in the 1990s, there was a surge of interest in stage hypnosis shows, probably owing to the activities of Paul McKenna, who gave popular televised performances. Owing to some legal claims of physical injury, including the tragic death of one participant (Heap, 1995), the possible hazards of stage hypnosis occupied much media attention, and numerous allegations of psychological injury were publicized. These included three lawsuits in which the present author was engaged for the defence. One of these is examined in detail in this issue (Heap, 2000). Another lawsuit, brought against McKenna, is the subject of a separate paper by Graham Wagstaff, one of the expert witnesses for the defendant (Wagstaff, 2000). In this paper I shall examine other cases and attempt to lay some ground rules for investigating claims made against stage hypnotists.

The law on stage hypnosis in the UK

In the UK, organizers of stage hypnosis shows in places of public entertainment must apply for a licence from the local council. This is enshrined in the 1952 Hypnotism Act. The act arose from some concerns about the safety of stage hypnosis. In 1948, a woman made allegations of negligence and assault against a stage hypnotist during one of his performances (*Raines-Bath* vs *Slater*). The plaintiff was initially awarded damages for negligence but the verdict was quashed on appeal (see Waxman, 1988).

Since then, there have been a number of published accounts by writers in the UK and abroad, in which it is claimed that psychological distress, and sometimes physical injury, were caused to a participant or even a member of the audience by the actions of a stage hypnotist (Erickson, 1962; Waxman, 1978, 1981, 1988, 1989; Kleinhauz, Drefuss, Beran, Goldberg and Axikri, 1979; Kleinhauz and Beran, 1981, 1984; Misra, 1985; MacHovec, 1986, 1988; Echterling and Emmerling, 1987; Crawford, Kitner-Triolo, Clarke and Olesko, 1992).

In the late 1980s, the UK Home Office drew up guidelines for the conduct of stage hypnosis to be attached to licences, with a view to protecting the participants (Home Office, 1989).

Recent allegations of harm by stage hypnotists

In more recent years, several cases have been the subject of private legal action. In 1995, a young man sued a stage hypnotist when he injured himself while running away from an imaginary army of giant mice. He claimed to have a phobia of mice. His case was unsuccessful. At about the same time, a woman successfully sued

Glasgow's Pavilion Theatre after breaking her leg when she fell off the stage during a stage hypnosis show.

In 1993, a healthy young woman, Sharron Tabarn, died during the night after taking part in stage hypnosis. The verdict of the inquest was death by natural causes. I have presented an analysis of this case elsewhere (Heap, 1995). The mother of the deceased understandably felt that stage hypnosis was a necessary factor in accounting for her daughter's death. She and others mounted a campaign to have stage hypnosis prohibited. She was also granted leave to appeal against the coroner's verdict on her daughter's death, and her lawyers presented a mass of documents to the royal courts. However, the judge considered that hypnosis was probably not implicated in her death and the original verdict was upheld.

Following the publicity stimulated by this campaign, other people came forward with accounts about how they too had been harmed by participating in stage hypnosis shows. As a result, at least four civil cases were brought against stage hypnotists by alleged victims. The author has examined documents relating to all of these, and has provided expert witness testimony in three. One of these has been discontinued without any settlement, one is ongoing, and I have provided an account of the third in this issue (Heap, 2000). The fourth is *Gates* vs *McKenna* (Wagstaff, 2000).

While these four cases were in progress, the UK Home Office set up a panel of experts to study evidence concerning the alleged dangers of stage hypnosis. The members of this group were psychologists and psychiatrists who had no particular expertise in hypnosis and therefore no prejudices either way. The report and recommendations of this panel were announced in October 1995 (Home Office, 1995). The panel concluded that stage hypnosis does not pose a significant mental health risk that would warrant its prohibition. After consulting a wide range of people the panel brought out a revised set of model conditions (Home Office, 1996).

Analysis of cases

It is clear from the documents that I have inspected in the above four cases that, in each instance, the plaintiff's side made a number of popular assumptions that are unwarranted or ill-supported from a study of the available scientific evidence concerning hypnosis.

Assumption 1: The stage hypnotist places the participants in a deep trance

In all of these cases the statements of claim by the plaintiff's side alleged that the stage hypnotist places the participants in a deep state of trance. For example, in one case it was asserted that hypnosis 'involves the interference with the conscious will of the subject(s)' and 'they are induced to perform acts that would be embarrassing and/or distasteful to them if fully conscious'.

It is not difficult to understand why such assumptions are made. Typically, the participants in a stage hypnosis show respond immediately and vividly to the suggestions given, as though they are indeed under the complete control of the hypnotist. Some of the stunts seem to call for quite unusual imagined experiences – as, for example, when a young man is told that he has fallen in love with a broomstick, or when all participants are told that someone in the audience has stolen their 'belly buttons' and they must find out who it is. At other times, when they are not required to be active, participants may seem to have entered some kind of stuporous state as they sit slumped in their chairs. Sometimes an individual who is noted for his or her calm

and reticent demeanour seems to undergo a personality change once he or she is up on stage and has been 'induced'.

There is every reason to believe that people will behave exactly like 'genuine' stage hypnosis participants if they are given enough incentive, such as money. However, the participants do not usually receive any material reward for their efforts. Nevertheless, some onlookers will simply interpret participants' activities as indicating that they are 'just acting'. Others, however, believe that they would behave in the way they do only if they were in some special mental state. This difference in interpretation is also evident among the participants themselves: some ascribe their outlandish behaviour to the fact that they were merely cooperating with the hypnotist; others have no ready and obvious explanation of why they responded in the manner they did – hence the explanation that the hypnotist puts them into a 'trance' and they are thus somehow under his or her power. Indeed, the fact that the stage hypnotist usually carries out a 'trance-inducing' ceremony at the beginning of the act and a 'trance-terminating' ritual at the end, serves to confirm this explanation. Moreover, because their behaviours and experiences are apparently so immediate and dramatic, people are inclined to believe that participants in stage hypnosis must be in especially deep trances or must be very deeply hypnotized.

Despite this, the evidence from the hypnosis literature indicates that under equivalent contextual demands and expectations, and possessing the same cognitive skills, commitment and involvement, 'non-hypnotized' participants are indistinguishable from participants who have been ceremonially 'put into a trance' (Barber, Spanos and Chaves, 1974; Kirsch, 1991).

This is actually implied in manuals of stage hypnosis (Meeker and Barber, 1971), and some stage hypnotists dispense with the 'trance-inducing' rituals altogether yet conduct their act in the same way. Prominent among these is the American illusionist and stage hypnotist George Kresge, *aka* 'The Amazing Kreskin' (Baker, 1990). Kresge specifically instructs his participants, whom he does not test for suggestibility, to remain awake and not 'go into a trance'. Similarly, in the UK, the magician Martin S. Taylor (Hoggart and Hutchinson, 1995) holds stage hypnosis shows without using hypnosis, sometimes in order to circumvent local prohibitions. Indeed, some *magicians* use stage hypnosis stunts, again without any attempt to 'induce hypnosis' – for example, the suggestion that the participants are unable to rise from their chair or that they are receiving an electric shock from their chair or from each other.

One can therefore state with confidence that the salient determining factors in the behaviour and experiences of the participants at a stage hypnosis show are their own skills, attributes and commitment to the task, the definite expectations concerning how they should respond, the effect of audience pressure, the stage hypnotist's demands, and the effects of being among a group of participants (see also Meeker and Barber, 1971).

One manifestation of these factors is the difference in the quality of the responses of stage participants and that of patients undergoing hypnosis treatment. For example, a patient responding to the suggestion of imagining being a child again will generally remain relatively unchanged in his or her demeanour, although occasionally he or she may speak in a soft voice, more child-like than usual; stage participants, on the other hand, fidget, giggle, jump off their chairs and run around, fight with one another, and so on. When told that they are riding a horse (perhaps in order to recreate feelings associated with their favourite pastime) patients may again show little change in their behaviour except perhaps for slight rhythmical movements of the

body; contrariwise, stage participants respond wildly, jumping up and down in their chairs, slapping their thighs, and so on. When given suggestions that they are feeling tired and sleepy, relatively little outward change is noted in the responses of patients, whereas stage participants slump in their chairs, drape themselves over one another, and even slide to the floor as though in a stupor. These differences in behaviour do not arise because the stage participants are 'in a deeper trance' or are 'more deeply hypnotized' than their counterparts in the clinic; in all three of the foregoing scenarios, patients in the clinic, despite minimal overt change, may report having profound and vivid experiences of the imagined or suggested effects. Clearly, the differences arise because the demands on the stage participants are that they must be immediately responsive and give a highly visible and flamboyant performance for the entertainment of the audience. Such is decidedly not the case in the clinic.

Nevertheless, we may speculate that defining the situation as 'hypnotic' has the following implications:

1. It may provide participants with a more potent excuse or justification for behaving in a disinhibited manner.
2. It will affect the way the participants explain their experiences and behaviour. For example, as was stated earlier, many participants will attribute their behaviour and experiences to their having been 'in a trance'.
3. Some participants may be more likely to assume that they are less able to resist the entertainer's instructions if they identify themselves as being 'hypnotized'.
4. The attribution 'hypnotized' as opposed to 'acting' or 'imagining' may itself have adverse consequences for some participants; this will be discussed in due course.

Assumption 2: Participants in a stage hypnosis show are extremely high in suggestibility or hypnotic susceptibility

Most stage hypnotists initially select their participants by their response to a simple suggestibility test, often the 'hand-clasp' suggestion, whereby members of the audience are told that they are unable to separate their interlocked fingers. These participants may then be put through a traditional trance-inducing ceremony, although some entertainers use a dramatic-looking 'rapid induction' method whereby eye-fixation on the hypnotist's hand is followed by the participant's falling backwards on to the stage floor with the hypnotist's assistance. Non-responders and uncooperative participants may then be deselected. Sometimes the number of participants is sufficiently large to allow further selection of the more entertaining members of the group, as the performance proceeds.

These preliminaries would not reliably select those who, in research papers, are identified by extensive psychometric tests as being of high hypnotic susceptibility; nor is it necessary to the performance that they do so. A person may prove to be a good subject for stage hypnosis for several reasons that are not related to hypnotic susceptibility. The ability to act in an improvised and hilarious manner is obviously one. It follows from these considerations, and those discussed under the previous heading, that one can make no reliable assumptions about people's hypnotic susceptibility by virtue of their participating in a stage hypnosis show, other than that they are more likely to be more susceptible than average. Evidence on the measured susceptibility of participants for stage hypnosis bears this out (Crawford, Kitner-Triolo, Clarke and Olesko, 1992).

Assumption 3: If the stage hypnotist does not cancel a suggestion properly then a participant may be compelled to respond to the suggestion on leaving the place of entertainment

Examples of such cases, given by Waxman (1978, 1988), are a man who continued the search for his navel and consulted a policeman, and a woman who squawked like a chicken every time she heard a whistle. A more recent case, reported in a tabloid newspaper (*The People*, 19 February 1995), concerned a man who filed a lost-property notice after he had been told that his brain had gone missing. The last-mentioned case may be dismissed as a stunt, but by what criteria? In this issue of *Contemporary Hypnosis* (Heap, 2000), I describe the case of a man who claimed to have experienced an overwhelming desire to have sexual intercourse with his furniture and domestic appliances following a stage hypnosis show. Two consultant psychiatrists and the man's general medical practitioner supported this claim on the basis that he was acting on a post-hypnotic suggestion.

Modern laboratory research, clinical experience and current theoretical understanding of hypnosis and suggestion indicate that a subject's response to a post-hypnotic suggestion is constrained in the following ways:

1. The suggested response must be within the subject's repertoire of abilities.
2. The response must be acceptable to the subject and compatible with the context in which it is given. For example, it is unlikely that the suggestion that the subject 'squawk like a chicken' would elicit that response in the clinical setting.
3. Although the suggestion may be experienced by the subject as having a compulsive quality, it involves cognitive effort on the subject's part (Barnier and McConkey, 1998) and may be overridden by the subject's own volition if such is demanded by the situation.
4. The influence of the suggestion is easily overridden by existing competing habits.
5. The subject's impulse to respond to the suggestion usually dissipates with time.
6. The influence of the suggestion is determined by the explicit and implicit demands of the context; when those demands are perceived as no longer operative, the subject stops responding. For example, in experiments on highly susceptible subjects, the response to post-hypnotic suggestion ceases when the experiment seems to have been temporarily suspended or when the subjects perceive themselves as no longer obliged to behave in the manner required by the experimenter; or even, although not always, when they are no longer under his or her surveillance (Fisher, 1954; Spanos, Menary, Brett, Cross and Ahmed, 1987).

Hence, the assertion that participants for stage hypnosis are endangered by the possibility of uncancelled suggestions is made on weak grounds. Of particular salience is the fact that when the stage hypnosis show has ended, important influences such as the context and the reason for acting on the suggestion are removed. This is not the case, say, after a session of clinical hypnosis, when the requirement is for the suggested response (for example, recalling a nauseous experience when putting a cigarette to one's lips) to persist in the person's everyday life; likewise in the case of a scientific experiment on the effect of post-hypnotic suggestions on the subject's everyday behaviour.

I shall later emphasize that any claim of injury following stage hypnosis should be framed according to established diagnostic criteria in medicine and psychiatry.

Perhaps, for example, a genuine instance of adverse and inappropriate perseveration of hypnotic responding could be explained in terms of obsessive-compulsive tendencies on the person's part. Such a person may feel compelled to continue responding because he or she believes that for some reason the requirement to respond is still operative (for example, 'the suggestion was not properly removed') and that *not* to respond would be (in the manner of obsessional thinking) problematical in some way.

Assumption 4: The stage hypnotist may not take a participant fully out of the hypnotic trance when the performance is over

This allegation was also made by the two psychiatrists and general practitioner involved in the case I describe in Heap (2000). Indeed, the initial diagnosis offered by the plaintiff's psychiatrist was that in the weeks after the stage hypnosis show, he had been in a 'trance-like, semi-hypnotic waking state'. Examples from the literature include that described by Kleinhauz and Beran (1981). This was a teenager who was admitted to hospital after participating in a stage hypnosis show. She had fallen into a deep stupor and could not be roused. Neurological and other medical investigations were negative, whereupon a number of psychiatric diagnoses were made without reference to her experience of stage hypnosis. She was in this condition for six days, at which point she was then seen by the main author of the paper, whose opinion was that she was in a pathological post-hypnotic state. The patient responded well to psychotherapy but after some months she was readmitted to hospital, once more in a deep stupor. No stage hypnosis was involved this time and the therapists therefore concluded that the girl was engaging in manipulation; her state of entrancement was now self-induced in order to control and punish her therapist for what she saw as his rejection of her, and was an attempt to regain his special attention.

In another, very anecdotal case described by Kleinhauz and Beran (1984), a male student had symptoms of acute psychosis, including bizarre behaviour, withdrawal, apathy, passivity and 'megalomania'. He had been previously hypnotized by a friend to help him prepare for an examination. The authors state, 'It is possible to conclude that his symptomatology had been entirely a product of a continuing hypnotic state' (1984: 287).

There is an obvious problem here of how one diagnoses a condition that has a limitless range of presenting symptoms, as revealed by the above examples. It is also clear from the discussion of assumption 1 that the notion that a person may remain wholly or partially in some special 'state of hypnotic trance' has little support in the scientific literature.

One interpretation of this assumption that may have some rational basis is to adopt a 'weak' definition of the notion of 'trance' – namely, a normal state of focused attention and detachment from ongoing reality (Heap, 1996). From this perspective we can say that a person who has 'not been adequately alerted from trance' is someone who may still be preoccupied with the thoughts, images, memories and feelings that he or she has been experiencing during hypnosis. On occasion, this may be hazardous (for example, if he or she has to drive home through busy traffic), but it is continuous with everyday experience and is normally transient and self-terminating. It may be that some individuals who have strong dissociative tendencies are more inclined to these after-effects. As well as this, where hypnosis has been used as a relaxation procedure, as with similar methods, individuals may feel groggy or drowsy on alerting, and may need some time to recover. However, this is not a special kind of

drowsiness or grogginess that is uniquely hypnotic and thus in some way especially dangerous or pathological.

None of this supports the contention that participants in stage hypnosis are at risk by the hypnotist's 'not releasing them from their trance', in the same way that a witch or wizard may not release a victim from a magic spell. The hypnotist's task is to inform the subject that the hypnotic session is now over (or the subject may make that decision for himself or herself) and it is time to orient himself or herself to the immediate present.

Some ground rules for assessing claims

Even without reference to actual claims of harm, it is not difficult to understand how, from a rational and scientifically informed consideration of the subject, stage hypnosis could, in certain circumstances, cause distress. Participants usually experience hypnosis as intense and unusual, and the term 'hypnosis' has 'spooky' and 'mind-controlling' connotations. Some people, especially those of an anxious nature, may regret participating, as they may believe that they were under the complete control of the hypnotist. The context of stage hypnosis may make it difficult for some participants to decline to respond or to disengage completely if they wish. A stage hypnotist may suggest an experience that a participant may usually find distressing – for example, engaging in an activity about which he or she has a phobia, or, in the case of a female participant, that she has lost one of her breasts and must find out who has it.

However, when assessing claims, it is important to acknowledge an essential fact, one which has emerged over the past 100 years of scientific inquiry – namely, that hypnosis is not a pathological state, and, where adverse reactions are evoked, these are not the result of any unique psychopathological features because of the person's experience of hypnosis.

It is necessary, therefore, that any claim of psychological injury due to stage hypnosis should be investigated on its own merits according to the following criteria:

1. The exact nature of the plaintiff's disorder should be described and defined according to established diagnostic criteria in medicine and psychiatry.
2. It should be made clear in terms of current knowledge of psychology and psychiatry how the complainant's alleged symptoms have been caused by the stage hypnotist's actions.
3. The possible role of hypnosis should be described with reference to current learned and scientific knowledge concerning the nature of hypnosis.

The case of *Gates* vs *McKenna*

This case, in which the plaintiff alleged that he had a schizophrenic illness after participating in a stage hypnosis show, is described more fully by Wagstaff in this issue (Wagstaff, 2000). In view of what has been stated earlier, it is worth mentioning that initially the plaintiff's psychiatrist offered a fairly orthodox, though highly tenuous, explanation of the possible causal connection between the plaintiff's experience of stage hypnosis and his subsequent mental illness. He contended that as schizophrenia is known to be precipitated by 'life events or environmental stressors', the plaintiff developed a schizophrenic illness because stage hypnosis is 'an environmental event

or stressor'. The term 'life event' as used here, however, seems to have acquired an extraordinary elasticity, and it is revealing that the same psychiatrist, in a report on another alleged victim of stage hypnosis, this time with a diagnosis of major depression, stated that depression may be precipitated by 'life events', the 'life event' in this case again being stage hypnosis.

It is not too difficult, therefore, to understand how the plaintiff's legal representatives were attracted to the idea that the state of mind into which their client was allegedly placed could be expressed in terms of neurophysiological changes, and that these changes, at least according to one line of theorizing, also underlie the condition that he allegedly had following the defendant's actions. Neither, however, it is difficult to acknowledge the great weakness of this stance.

It is instructive to compare this claim with an example of the persistence of psychological disturbance following neurological insult, namely post-concussional state. It is established beyond doubt that a blow or sudden jolt to the head may have neurological effects described as 'concussion', and that these may be corroborated by physical examination of the patient at the time. There is good evidence that even a year later some effects (headache, lack of concentration, irritability, and so on) may persist (Blakely and Harrington, 1993; Wright and Telford, 1996). Extensive neurological and neuropsychological examination and brain scanning may raise the suspicion of residual organic impairment. Yet in any individual personal injury claim, it may still be difficult to make a convincing case of post-concussional syndrome, and the defence may readily find expert witnesses to challenge this diagnosis (Bohnen and Jolles, 1992).

One great weakness of the plaintiff's case was that it was speculated, largely on a theoretical basis, that the verbal communications of the defendant triggered clinically significant changes in the plaintiff's neurophysiological functioning. Again, on theoretical grounds, the plaintiff's psychiatric symptoms were linked to these putative neurophysiological changes. Yet no results of any neurological examination, brain scan or neurological assessment were offered by the plaintiff's side.

In this case the plaintiff's problem was schizophrenia, yet, prior to this case no authoritative writer was seriously arguing that 'hypnosis causes schizophrenia'. Neither was there any good evidence that hypnosis or stage hypnosis could precipitate the mental deterioration that Gates reportedly displayed in the days and months following his experience.

These considerations raise the question of how one may demonstrate negligence in such a case and whether the defendant could reasonably have foreseen and forestalled the harm that was alleged to have transpired through his actions. For obvious reasons, the UK Home Office model conditions on stage hypnosis (Home Office, 1996) do not require that the entertainer conduct a mental state examination on his or her participants. He or she is advised to inform the audience that participants should be of 'normal physical and mental health'. However, the plaintiff's side in this case asserted that he had no history of psychiatric problems nor was there anything to suggest that he was at risk of developing a mental illness.

Notwithstanding this, anyone reading accounts of *Gates* vs *McKenna* (Wagstaff, 2000) will ponder the following: whether or not this question applies to this particular case, is it advisable for a person with a psychotic predisposition to take part in stage hypnosis? Intuitively, from the earlier discussion of the possible hazards of stage hypnosis, one is likely to feel that this is not the sort of activity in which someone with psychotic tendencies should engage.

Conclusions

People who use hypnosis in therapy, or who investigate hypnosis from a scientific standpoint, can feel no particular obligations to stage hypnotists. I, for one, am convinced that when hypnosis is used for the purposes of entertainment it gives the public a completely misguided impression of what it actually is and how it may be used therapeutically. However, we must hold steadfast to a rational and scientific understanding of the subject, one that is consistent with mainstream psychology, the neurosciences and their related disciplines. This requires an attitude of impartiality and objectivity when one is asked to assess claims of harm against untrained 'hypnotherapists' or stage hypnotists. In this paper I have attempted to set some ground rules for this kind of work, which have these considerations in mind.

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