Conversational Assessment of Hypnotic Ability to Promote Hypnotic Responsiveness

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In this article, hypnotic responsiveness is conceptualized as the byproduct of hypnotic ability, which is largely unalterable, plus hypnotic participation, which is highly subject to manipulation in the therapeutic context. This framework constitutes the basis of a model for the conversational assessment of hypnotic ability and hypnotic participation, as well as the subsequent tailoring of therapeutic interventions based on that assessment. Specific clinical steps for implementing activities implied by the model are explained and then demonstrated by way of a case example.

Clinical researchers have long emphasized the importance of assessing hypnotic capacity in the clinical setting. Mott (1979) suggested that the benefits of assessment are both prognostic and diagnostic, including confirmation of relationships among hypnotic capacity, responsiveness, and diagnostic categories. Relatedly, Frankel and his colleagues (1979) observed that patients generally had a positive reaction to the use of scales to measure hypnotic capacity.

Despite enthusiasm for the usefulness of such scales, concerns about the assessment of hypnotic capacity in clinical practice have also been raised. Gruenwald (1982) suggested that formal measurement in the clinical setting may attenuate optimal performance and generate resistance to performing tasks requested by the scales. Sacerdote (1982) suggested that scales give disproportionate weight to certain categories of hypnotic activity, and rely on only a limited class of inductions. Given that formal measures rely on failure to establish the ceiling of ability, there may be a concern about introducing failure into the therapeutic experience. Regardless of whether
it is a good idea or clinically important to formally assess hypnotic capacity, few clinicians regularly do so (Cohen, 1989).

Traditionally, it has been argued that if clinicians would simply formally assess susceptibility, they could improve their clinical work. However, many clinicians view hypnotic capacity as irrelevant to their work. Rather, they have relied exclusively on tailoring suggestions to individual patient needs and resources as a way to develop more effective hypnotic interventions.

Hypnotic susceptibility is relevant to clinicians insofar as it can assist in predicting the relative ease of responding to a wide range of hypnotic suggestions and interventions (Hilgard & Hilgard, 1965). As has long been observed, overall responsiveness to a given hypnotic intervention is more than just a function of innate hypnotic ability (cf. Price & Barber, 1987). That is, hypnotic responsiveness is also a function of a variety of interpersonal (Diamond, 1984), contextual (Gorassini & Spanos, 1986), attitudinal (Spanos, Brett, Menary, Cross, 1987), cognitive (Diamond, 1984), and personality (J. Barber, 1991; Bates, 1992) factors that have been described in the literature and must be considered when attempting to describe and understand a given patient’s response to a specific hypnotic intervention. For instance, in their work with pediatric cancer patients, J. Hilgard and LeBaron (1984) observed that different types of imaginative involvement optimized hypnotic responsiveness and pain control. In summary, in order to maximize the patient’s hypnotic experience, the clinician must assess hypnotic capacity and bring into play the gamut of factors related to increasing hypnotic participation and suggestibility.

A Conceptual Model

In this article we propose a conceptual model for assessing potential hypnotic responsiveness and for tailoring individualized hypnotic strategies. Our goal is to assist the clinician in shaping hypnotic participation and fortifying the patient’s hypnotic experience in order to promote the success of clinical treatment. The viability and clinical import of the activities suggested by the model are enhanced by their being embedded within naturally occurring conversations between patients and clinicians in the early phases of their contact. Before proceeding further we will define terms that are relevant to the proposed model. Hypnotic ability, hypnotic capacity, or hypnotizability index is an innate or hard-wired stable trait that is not directly measurable, but it is instead inferred from performance on standardized scales of hypnotic suggestibility. Hypnotizability scores or hypnotic susceptibility refer to an estimate of hypnotic ability derived from performance on a standardized scale. Hypnotic involvement, in turn, refers to the depth of “trance” experienced by the participant. Hypnotic participation is the patient’s goal-directed, motivated engagement in the hypnotic experience. Hypnotic responsiveness refers to the sum total of contributing factors that affect responses to particular suggestions or interventions. By hypnotic experience, we refer to the combination of hypnotic responsiveness, hypnotic involvement, and hypnotic participation. Finally, the term individual patient resources refers to the combination of cognitive, contextual, and interpersonal factors that are unique to a given patient and that can be adapted or utilized to enhance the hypnotic experience.
We contend that a patient’s responses to hypnotic interventions are shaped by a dynamic interplay between the clinician’s manner of presentation and the styles and traits exhibited by the patient. Further, this interaction occurs in the context of an emerging interpersonal relationship, within a set of cognitive, behavioral, and experiential tasks, the fulfillment of which are related to the individual’s hypnotic capacity. By carefully tailoring what is said and how it is said, clinicians can promote positive rapport and an effective therapeutic alliance, and thereby amplify the opportunity for meaningful and effective participation in treatment. The patient’s response to such tailored interventions becomes the interactional pathway into maximal hypnotic involvement and experience of hypnosis.

The basis for the conversational assessment of hypnotic responsiveness is a clinical interview focused on dimensions of a patient’s experience that have been shown to be related to successful response to hypnotic suggestions. Conversational assessment is an extension of the standard clinical interview; it provides essential information about past behavior, fosters patient involvement, and provides an opportunity to observe how readily the patient becomes engaged in aspects of hypnosis that are relevant to optimizing the cognitive, behavioral, and interpersonal experience of hypnosis. In short, talking about past hypnotic-like experiences becomes a vehicle for assessing and eliciting hypnotic experience and optimizing treatment gains.

A major goal of assessing the potential for hypnotic responsiveness is to determine the range of hypnotic phenomena to which a given patient would likely respond. High versus low susceptibility carries logical consequences both for the types of phenomena that might reasonably be suggested and manifested, and for the way in which a particular intervention might be tailored in clinical practice. Hypnotic capacity can be estimated in terms of patient self-report or in-session observation of such domains as the ability to engage in absorbing activities, openness to novel experience, the ability to generate vivid visual imagery, and physical self-regulation.

We recommend that the assessment of potential for hypnotic responsiveness consist of the following steps: (a) assess innate hypnotic capacity; (b) select the most appropriate range of hypnotic phenomena to initiate or facilitate treatment, with the recognition that different portions of the identified range have different implications for how to tailor a given intervention; and (c) assess performance along dimensions related to hypnotic involvement. These steps will be described in more detail below. However, it is important to underscore the point that the clinical purpose of susceptibility assessment is to distinguish patients who can respond to interventions that require relatively high levels of hypnotic ability (i.e., absorbing interventions) from patients who require modifications of the treatment context to enhance expectancies and proactive learning strategies to promote hypnotic involvement. As such, the goals of assessment are: (a) to determine if promoting innate skill or using learning strategies will be the primary vehicle to optimize response, and (b) to identify dimensions around which to tailor interventions.

**Conversational Assessment of Hypnotic Ability**

We have noted that some sense of hypnotic capacity is necessary to give the clinician the requisite tools to enhance hypnotic responsiveness. Because we do not believe that most clinicians will modify their behavior in significant respects and use a
formal measure to gauge susceptibility, we propose another strategy. We suggest that information gleaned from a discussion of past propensities to have hypnotic-like experiences in everyday life, and/or observing the patient’s hypnotic-like experiences during conversations about hypnosis will permit a rough assessment of the patient’s hypnotic strengths and weaknesses and provide an estimate of hypnotic capacity. That is, within the clinical session, having a conversation about motivation, receptive attitude towards hypnosis, openness to relationship development, absorption, imaginative involvement, ease of changes in physiology, and so forth, will yield valuable information relevant to dimensions associated with innate hypnotic capacity. This process also allows a clinician to observe a patient’s response to conversation about dimensions of interest and to note if hypnotic participation is generated during the conversation itself. This conversational assessment produces both an estimate of susceptibility, and a targeted set of strategies around which to tailor interventions to promote responsiveness. The clinician’s ability to do so enhances the opportunity for successful hypnotic experience.

Support for the idea that clinical observation can be used to assess hypnotic susceptibility derives from a number of studies. In a study of 23 patients, Shor, Orne, and O’Connell (1966) found a correlation of .75 between scores on the Stanford Form A and a four-point rating scale that corresponds to the Davis Husband Scale, an observational rating of the degree to which a subject appeared hypnotized. Evans and Thorne (1966) found a correlation of .77 between the Stanford Form C and a five-point observational hypnotizability rating scale in a sample of 60 subjects. In a study of 63 subjects, O’Connell, Orne and Shor (1966) counterbalanced the SHSS:A and a 5-point rating scale of (1 = unhypnotizable to 5 = deeply hypnotizable). The correlation between measures was .79. More recently, Pekala (1991) has developed a patient self-report measure, the Phenomenology of Consciousness Inventory (PCI), which assesses affect, altered experience, imagery, absorption, attention, self awareness and altered state of awareness, internal dialogue, volitional control and awareness. Comparing scores on this self-report to scores on the Harvard Group Scale of Hypnotic Susceptibility has produced correlations between .51 (Pekala, 1995) to .62 (Pekala & Kumar, 1984). These statistical relationships are similar in magnitude to those that have been demonstrated between such standardized measures as the Hypnotic Induction Profile and the Stanford Hypnotic Susceptibility Scales (Sheehan & McConkey, 1982). These data further support the relationship between clinical observation and formally measured hypnotic susceptibility.

**Clinical Assessment and Tailoring Interventions: Fundamental Steps**

“Tailoring” hypnotic interventions involves selecting interventions that will enhance a patient’s hypnotic experience based on an assessment of hypnotic capacity and the potential for hypnotic involvement. The specific steps involved in clinical assessment, decision-making, and subsequent tailoring of interventions to optimize hypnotic responsiveness can be summarized as follows:

1. Assess hypnotic capacity by engaging in a conversation that reviews past and present experiences relevant to attitudes about hypnosis, ease of establishing a therapeutic relationship, capacity for absorption, vividness of imagination, dissociation, and purposeful
changes in physical functioning such as alterations in skin temperature or heart rate (i.e., self-regulation). Rather than simply summing responses, pay particular attention to the patient’s responses to imagino-sensory tasks (e.g., generating vivid imagery) versus motoric tasks (e.g., responding quickly and easily to suggestions for movements). The goal is to evaluate whether the patient has skills in enacting one or both tasks in order to devise interventions that capitalize on the patient’s strengths.

2. Assess if the patient exhibits hypnotic-like involvement during the current session by evaluating physical activities (e.g., eye closure, change in respiration, and body immobility) that are clinically associated with hypnotic involvement.

3. If the patient seems to possess sufficient hypnotic capacity and current involvement to benefit from a traditional hypnotic procedure, proceed accordingly. That is, continue to reinforce current hypnotic involvement using traditional principles and methods of hypnotic induction (e.g., repetition of direct suggestions), along with deepening procedures, and use of a variety of hypnotic suggestions targeted to specific treatment objectives.

4. If there are few or no indications of hypnotic capacity and involvement, use the information gleaned from the interview to tailor interventions that facilitate rapport, positive attitudes and expectations about hypnotic capacity, imaginative involvement, and active participation in the events of hypnosis (Gfeller, 1993).

Specific steps for assessment and tailoring interventions include:

A. Engage in an initial conversation about how clinical time could be used productively while simultaneously attending to ways of interacting that enhance the therapeutic relationship.

B. Continue questioning about prior hypnotic-like experiences and focus particular attention on the how and what of these experiences (e.g., how does the patient engage in absorbing experiences; what do they do to achieve that absorption?)

C. Observe whether revivification of the patient’s prior experiences or the clinician’s use of intonation, rhythm of speech, and word selection generate involvement in hypnotic phenomena such as generalized physical quieting, altered respiration, gradual eye fixation, eye closure, and so forth.

D. Questioning should continue until the clinician has determined: a) the degree to which the patient can easily engage in various aspects of hypnotic experience based on the patient’s rendition of historical events and current interview behaviors; b) which components of experience are more or less difficult for the patient. The greater the number of aspects of successful hypnotic performance that are
5. Identify attitudes, ways of thinking, feelings, behaviors, and experiences that are particularly meaningful to the patient. The more rapidly a patient becomes successfully involved in the events of hypnosis, the more rapidly the operator should respond. Slower patient response may mean moving more slowly and at the patient’s pace. In such cases, teach, model, rehearse, and practice new activities that promote hypnotic involvement. Keep in mind that it may be necessary to proceed slowly for the duration of the intervention, and that certain hypnotic phenomena, although often ultimately possible to achieve, will probably remain difficult with such patients.

**Case Example**

A 34-year-old woman was referred for hypnosis by her obstetrician. She was in the 26th week of her second pregnancy. Her first pregnancy had resulted in a cesarean section because of her cervix did not dilate adequately. Karen (an altered name) described the procedure as “the most horrible, painful thing that has ever happened to me.” The current pregnancy was unplanned and she was fearful of pain and the possibility of a second cesarean. Karen was clear that there was nothing I (R.S.K.) could do, that hers was a physical problem, and that hypnosis was the last thing she needed.

Diagnostic questioning revealed an internal locus of control; initial negative affect; limited ability to engage in relationships; little imaginative, dissociative or absorptive capacity; and a history of difficulty relaxing either mentally or physically. Assessment suggested a limited history of engaging in dimensions associated with hypnotic capacity and a lack of desire or motivation to engage in a hypnotic experience. She was assessed to have lower hypnotic capacity and little hypnotic participation. She also evidenced no interest in using hypnosis or evidence of hypnotic involvement during the interview.

The initial intervention attempted to facilitate rapport and foster the positive expectancy necessary for hypnotic responsiveness to be optimized. I assured her that it was important for her to stay in control so that the remainder of her pregnancy would go well, and that I understood how very upsetting it must be for her to have difficulty communicating with her obstetrician. With that, she acknowledged that close relationships with men were very difficult for her, and that “My obstetrician keeps telling me to relax with medicine or relaxation tapes, and I know I should relax but I just can’t.” When I wondered why she could not, Karen said that she had always been physically and mentally tense and that she was very concrete in her thinking. “When the relaxation tapes talk about daydreams or imagining, it’s nothing that I’ve ever done and I worry that if I could do it I’d fall to pieces and lose control.” I then
asked her to think about whether it would be useful to continue meeting, and if she did, to schedule another appointment. Despite her residual guardedness, her initial anger and negative affect had lessened and she indicated that she at least thought that relaxation, while unfamiliar to her, was important. Her attitude had shifted enough to make it likely she would return for treatment. Karen did reschedule and after reviewing the prior session and confirming that she had a good experience, I asked if she had done anything since our last session. She said that she had gone to the library “and discovered there were some facts about hypnosis and pain I didn’t know about.” She said she often went to the library and read a lot, mostly nonfiction and some historical novels. Since “facts about hypnosis” were both something that she had actively sought out and to which she was clearly receptive, it was evident that available and useful individual resources could be used to tailor my next intervention.

Using facts about childbirth, labor, and pain, I described the physiology of the birth process up to and through labor and delivery, and the facts about stress, relaxation, and effacement and dilation. I also used the facts metaphor to positively introduce self-regulation of muscle tension, heart rate, and oxygenation, as well as the relationship between cognitive activities and self-regulation. This was also the first time in treatment that I overtly used explicitly hypnotic strategies and presentation style such as altering voice tone, rhythmic presentation, and intonation. Her response to these interventions required a more extended period of time than for patients who become easily involved. However, over the course of the session, she displayed observable changes in respiration, muscular relaxation, eye fixation, and body quieting, all consistent with initial levels of hypnotic participation.

At the beginning of the third session, her previously reserved stance had disappeared and our interaction was pleasant and open. Karen noted that she was interested in pursuing hypnosis but was still not sure if it could help her, and she still didn’t know how to do it. Relying as an individual resource on her interest in and safety with reading, I asked her what it was like when she read. At first, the question was confusing and she was not able to respond. After engaging in internal search she was able to acknowledge that she was quiet, that her attention was concentrated, and that sometimes she did not hear other things in her house when she read. When I asked her what reading felt like physically, she said that she did not know. Focusing on the book she was currently reading (a history of dairy farming in New England), I asked if it would be all right if she closed her eyes and imagined and remembered the last chapter she had read. She said she did not know if she could do what I asked, but she closed her eyes, sat silently without moving for about five minutes, and evidenced slow even respiration and bodily quieting and muscular relaxation. I was satisfied that her responses were indicative of hypnotic involvement. At some point she said, with her eyes still closed, “My body is different now. I never noticed it; it is almost like since my mind was concentrating on something, my body just got comfortable. It would not work if you told me to relax.” When her eyes opened, Karen smiled and said, “Let’s find out how to use this to deliver my baby.” She was able to engage in a hypnotic experience that was sufficient to encourage her to believe that hypnosis could assist her delivery.

We continued to rely on active discussion of facts about childbirth and the reading the book metaphor as a way of acquiring information and learning how to modify her experience by practicing psychological and physical self-regulation. We
continued to work with hypnosis in this manner for three more sessions that focused on diminished anxiety, pain management, and successful vaginal delivery. Shortly afterward, Karen went on to a successful vaginal delivery, with a four-hour labor, and a healthy female child.

Despite assessment of a paucity of initial skills and experiences associated with hypnotic capacity and despite no initial hypnotic participation, we used a skill-training model to work effectively to create a successful hypnotic experience. Tailored clinical interventions were generated from data gathered by a conversational assessment, allowing Karen to develop hypnotic participation and responsiveness and to use this hypnotic experience successfully in preparation for the birth of her child.

Summary and Conclusions

Discussions about the clinical relevance of hypnotizability have suffered from imprecision in language, which tends to ignore the distinction between “hypnotizability” and the more general phenomenon of hypnotic responsiveness. We propose hypnotic responsiveness as a function of hypnotic capacity plus hypnotic involvement. This allows us to explain why clinicians can indeed be more effective than normative data derived from hypnotizability scales would predict. The taxonomy we have proposed provides a framework for a theoretically driven model to facilitate the conversational assessment of hypnotic capacity and to assist the clinician in tailoring therapeutic interventions based on that assessment.

Clinically focused conversations about past experiences that emerge within the context of a therapeutic relationship, which is itself to some degree shaped by hypnotic capacity, can be used to generate data to tailor individualized hypnotic strategies and to elicit and facilitate current hypnotic experience. For patients with lesser hypnotic capacity, hypnotic participation is the fulcrum point for effective clinical work. By identifying specific factors that can be a taught, shaped, developed, and practiced and ultimately experienced by the patient, it is possible to optimize hypnotic involvement and responsiveness by maximizing hypnotic participation.

Because the factors related to hypnotic ability have not been identified with precision, and because the clinical model presented in this paper is in its initial stages of development, it is hoped that the ideas in this paper are of sufficient interest to warrant empirical investigation. Specifically, it is important to know whether well-trained clinicians can predict susceptibility at levels comparable to formal measurement. Another important question is whether tailoring interventions to the logical consequences of higher or lower susceptibility has an impact on hypnotic involvement or hypnotic outcomes? The proposed model should assist clinicians in implementing a data-based assessment and treatment in which research and clinical practice are partners in the therapeutic enterprise.

References


