The Role of Hypnotizability Assessment in Treatment

Steven Jay Lynn
Kelley Shindler
State University of New York at Binghamton

Disparate opinions about the importance of the assessment of hypnotizability reflect very different ideas about what hypnosis is, the relevance of hypnotizability to psychotherapy and treatment outcome, and the importance of gathering scientific data to document treatment effectiveness and the presence of hypnotic effects. In this article, we argue that in recent years important developments have occurred in the conceptualization, assessment, and technical aspects of hypnotic intervention that imply that clinicians who eschew the use of hypnotizability assessment ought to reconsider their position. In making this argument, we will discuss reasons for assessing hypnotizability, the relation between hypnotizability and treatment outcome, and practical considerations in the assessment of hypnotizability.

Sixteen years ago, at the annual meeting of the American Society of Clinical Hypnosis, Sheldon Cohen circulated a 1-page questionnaire at the general meeting of workshop faculty members. This questionnaire surveyed the faculty about their use of measures of hypnotizability in their clinical practices. The responses of this experienced group of therapists were enlightening. Of the 37 faculty members who responded to the questionnaire, only slightly more than half (54%) had ever used tests of hypnotic responsiveness. Of this number, 24% of the participants had abandoned the use of tests, leaving only 30% of the faculty current users of hypnotizability tests.

Cohen’s report spawned a number of highly diverse opinions about the clinical relevance of hypnotizability in a commentary section of the American Journal of Clinical Hypnosis in which the survey was published. Diamond (1989) argued that quantitative measures can, at best, provide only a gross index of general hypnotic

This article is based on a paper by the same title presented at a symposium at the 18th ASCH Annual Scientific Meetings and Workshop, Orlando, Florida, March, 1996. Portions of this article were also based on a chapter entitled “Clinical hypnosis: Assessment, applications, and treatment considerations” (Lynn, Kirsch, Neufeld, & Rhue, 1996) that appeared in the Casebook of Clinical Hypnosis (Lynn, Kirsch, & Rhue (Eds.), American Psychological Association). We thank Jessica Lynn for her assistance with the preparation of this manuscript.

Steven Jay Lynn, PhD, ABPP
Psychology Department
State University of New York at Binghamton
Binghamton, NY 13905
ability, rather than mark the specific imaginative, dissociative, and absorptive skills necessary to respond to therapeutic suggestions. At worst, he stated, hypnotizability assessment is risky business and is a potentially “misleading, intrusive, and transference-contaminating obstacle to the therapeutic work ahead” (p. 12). Diamond’s comments imply that failures in the course of hypnotizability testing can beget failures in clinical hypnosis and psychotherapy. Diamond (1989) contended that it is rarely the case that something is learned from a standardized test of hypnotizability that cannot be learned more efficiently, and with less risk to the clinical relationship, using other techniques.

J. Barber (1989) made a similar argument in emphasizing the distinction between hypnotizability scores and hypnotic capacity. According to Barber, hypnotizability scales do not measure the capacity to respond in a clinical situation, rendering questionable the assumption that knowledge of hypnotizability scores can be clinically useful. Barber acknowledged, however, that even though knowing a patient’s hypnotizability does not guarantee clinical success, it might make clinical work more efficient. That is, with a highly responsive patient, he would use simple, direct suggestions; with a less responsive patient, he would tend to take more time and be more indirect (e.g., use of metaphor) in his approach.

H. Spiegel (1989) also cited efficiency as a potential benefit of testing. Much unnecessary and nontherapeutic interaction could be avoided, he claimed, if levels of hypnotizability could be accurately and quickly assessed. Spiegel recommended that the Hypnotic Induction Profile (HIP; Spiegel & Spiegel, 1978) be used for assessing hypnotizability, noting that it can also identify those clients who can optimally benefit from hypnotherapy and psychotherapy in general. According to Spiegel, the HIP can provide useful information about not only dissociative capacities, suggestibility, and absorption, but also the degree to which a person is malleable and can ‘focalize concentration and internalize and control a new perspective’” (p. 16).

Of all of the commentators, only Rossi (1989) was seemingly dead-set against the use of hypnotizability scales, stating that “…sensitive and humanistically oriented therapists avoid subjecting their already wary and weary patients to yet another power-trip, thinly veiled as “an objective measure of hypnotic susceptibility” (p. 15). Rossi did, however, hold out the hope that if and when researchers develop standardized methods of evaluating and facilitating mind-body healing and the interpersonal process of suggestibility, “clinicians will be sure to beat a path to their door” (p. 15). With the exception of Rossi, all of the commentators, including the Editor of the American Journal of Clinical Hypnosis, Thurman Mott, believed that hypnotizability assessment was essential to documenting the effects of hypnotic interventions and to attributing treatment gains to hypnosis-related experiences.

These disparate comments reflect very different ideas about what hypnosis is, the relevance of hypnotizability to psychotherapy and treatment outcome, and the importance of gathering scientific data to document treatment effectiveness and the presence of hypnotic effects. There are probably as many views of if, when, and why a clinician ought to assess hypnotizability, as there are views about the role of psychological assessment in psychotherapy. Nevertheless, since Cohen’s study, important developments have occurred in the conceptualization, assessment, and technical aspects of hypnotic intervention that suggest that clinicians who eschew the use of hypnotizability assessment ought to reconsider their position.
Reasons for Assessing Hypnotizability

Hypnotic Responsiveness is Multi-Factorial

Assessment can contribute to an understanding of the various components of hypnotic responsiveness and thus play a role in optimizing responsiveness to hypnotic procedures. Hypnotizability is not a singular ability that is isolated from the whole person and his or her response to changing environmental demands and contingencies. If hypnosis could, in fact, be equated with a particular ability such as dissociation, absorption, or fantasy proneness, it would be a simple matter to administer tests of one or more of these constructs and predict hypnotizability with a high degree of confidence. Unfortunately, measures of dissociation, absorption, and fantasy proneness are only weakly correlated with hypnotizability and have very limited predictive value (see Council, Kirsch, & Grant, 1996). For instance, Putnam (1994) has recently reported that the average correlation of dissociation with hypnotizability, across 14 studies, is $r = .15$.

Rather than a single ability underlying successful responding, a variety of variables influence hypnotic responsiveness. These multifarious influences include attitudes, beliefs, and expectancies about hypnosis; the standards clients use to evaluate their responses (Lynn, Green, Jacquith, & Gasior, in press); imaginative abilities; the rapport with the hypnotist; how participants interpret suggestions, and their motivation to respond to hypnotic suggestions (Lynn & Rhue, 1991). Each one of these factors can be assessed and potentially augmented during hypnosis.

The value of such an approach is confirmed by a considerable body of research on the modification of hypnotizability (see Gfeller, 1993; Spanos, 1986, 1991). This research indicates that more than half of participants who initially test as low hypnotizable can test in the high hypnotizable range on a variety of assessment instruments, after appropriate rapport is developed and participants are properly motivated to respond and use a variety of cognitive-behavioral skills in the hypnotic context. Indeed, clinicians can learn a great deal from the following steps researchers have taken to instigate large-scale increments in hypnotic responding: (a) bolstering positive response expectancies, (b) encouraging clients to use their imaginative abilities and to establish lenient criteria (e.g., defining hypnosis as cooperation rather than a “trance”) for experiencing themselves as “hypnotized,” and (c) teaching clients to play an active role in responding to suggestions, such as for hand levitation. Gfeller (1993) has written perceptively about how hypnotizability can be individually tailored and enhanced in clinical situations.

This approach presupposes that the therapist assesses multiple components of hypnotic responding and conducts an assessment that goes well beyond a formal test of hypnotizability. With each client, the decision to use hypnosis should be preceded by a thorough evaluation of the person’s mental status and psychological dynamics, their presenting problems and goals for therapy, and their beliefs and expectations about hypnosis (Kirsch, Lynn, & Rhue, 1993). Assessment of the client is necessary to screen out candidates who are inappropriate or less than ideal for clinical hypnosis. Clients who are vulnerable to psychotic decompensation (Meares, 1961); those with a paranoid level of resistance to being controlled (Orne, 1965); unstabilized dissociative or posttraumatic clients; and clients with borderline character structure for whom hypnosis may be experienced as a sudden, intrusive, and unwanted intimacy may all...
be poor candidates for hypnosis or require special attention or modification of typical hypnotic procedures to emphasize safety, security, and connectedness (Murray-Jobsis, 1996).

When assessment reveals deeply ingrained negative attitudes about hypnosis, it may be prudent to defer hypnosis or to conclude that hypnosis is not a viable treatment avenue well in advance of hypnotizability testing. Likewise, if a client has positive expectations and attitudes about an alternate treatment, this ought to be considered in the treatment plan.

This approach implies that before a formal assessment of hypnotizability is undertaken, the therapist should: (a) evaluate the client with respect to multiple dimensions of concern, (b) discuss the possibility of using hypnotic techniques in treatment, and provide the client information that dispels myths and misconceptions about hypnosis that can abridge a complete response. Finally, it is imperative to identify and circumvent potential sources of resistance to hypnosis that preclude a valid measure of hypnotic potential or capacity.

Assessment, Hypnotic Responsiveness, and Treatment Outcome.

Why might we wish to assess hypnotizability before we integrate hypnosis into psychotherapy? One reason to assess hypnotizability is if there are great costs associated with the failure to hypnotize someone, or if there are clear benefits associated with a positive response to hypnosis. One situation that comes to mind is hypnotizing a dental patient who contemplates undergoing painful dental procedures without analgesia due to an allergic response to analgesics. It would be foolhardy to hypnotize a patient in a dental situation who failed to demonstrate appreciable hypnotic talent and demonstrable pain relief prior to the dental procedure.

Pain reduction

As our discussion implies, knowledge about a client’s hypnotizability is critical in the area of pain reduction. A 1996 National Institute of Health Technology Assessment Panel Report judged hypnosis to be a viable and effective intervention for alleviating pain with cancer and other chronic pain conditions. Recently, Montgomery, DuHamel, and Redd (2000) conducted a meta-analysis of hypnotically induced analgesia and found that hypnoanalgesic effects varied according to hypnotizability, especially when people highest in hypnotizability were compared with individuals low in hypnotizability. However, it has been demonstrated (Stam & Spanos, 1980) that if a person is low hypnotizable, they will not respond to hypnotic suggestions for analgesia, but may respond to analgesia suggestions that are not couched in “hypnotic” terms. So, in this instance, knowing something about a person’s hypnotizability level could assure that the therapist is able to redefine, when necessary, and tailor interventions to maximize treatment gains.

Smoking cessation

Similarly, when we administer smoking cessation treatments, we routinely test clients for hypnotizability. Research indicates that motivation for quitting is a crucial factor in achieving long-term smoking cessation (Green & Lynn, 2000). Although the research on the relation between hypnotizability and treatment outcome is mixed (Green & Lynn, 2000), it is likely that if a treatment is defined as hypnosis,
and the client is not responsive to suggestions, it could dampen motivation and positive expectancies and attenuate treatment gains. Many hypnotic approaches could just as easily be called “imagination” or “goal-directed fantasy,” and still retain their effectiveness. Accordingly, it is important to have at least a general idea about how hypnotizable a person is, as well as the individual’s attitudes and expectancies about potential treatment options.

*Psychological conditions and disorders*

As our discussion implies, assessment of hypnotizability is important because research has established that a link exists between hypnotizability and certain disorders and conditions and their successful treatment with hypnotic interventions. Actually, many of the earliest hypnosis researchers embraced the idea that hypnotic responsiveness and psychopathology were intimately related. These notions began with Janet and Charcot and were carried over from the 19th to the 20th century. Early studies attempted to establish a connection between neuroticism, repression, and various subscales of the MMPI and other measures of psychopathology. While some of these studies yielded positive findings, far more failed to demonstrate the hypothesized correlations (de Groh, 1989). Brown (1993) also describes early unsuccessful attempts to predict hypnotizability via knowledge of patients’ diagnoses and other factors such as gender, introversion/extraversion, social status, ethnicity, and intelligence.

Recently, however, research has provided evidence for an association among hypnotic responsiveness, psychological conditions, and potential treatment success. For example, individuals with posttraumatic stress disorder (see Cardena, 2000) and bulimia (see Pinnell & Covino, 2000) exhibit relatively high levels of hypnotizability, which might make them particularly good candidates for hypnotic interventions. With respect to other disorders such as phobias (Crawford & Barabasz, 1993), asthma (Ewer & Stewart, 1986), and somatoform disorders (Wickramasekera, 1993), there are good empirical and theoretical reasons to support a link between hypnotizability and treatment outcome, even though the association may be mediated by imaginative processes and expectancies. Whereas it once was thought that hypnotizability was largely irrelevant to treatment outcome in the case of obesity, a review of the literature (Levitt, 1993) indicates that high hypnotizability appears to be related to long-term maintenance of weight loss. Although the evidence pertaining to hypnotizability and treatment outcome of dermatological conditions is mixed, vivid suggestion-related imagery is associated with treatment success and wart loss (Dubriel & Spanos, 1993).

*Trauma resolution*

Hypnotizability assessment is invaluable when trauma resolution work is contemplated. One of the most robust findings of the literature on suggestion and memory is that hypnotically created memories, or pseudomemories, as they are called, are most likely to occur in participants who are at least moderately hypnotizable (see Lynn & Nash, 1994). Therapists should avoid doing memory recovery work, given the many pitfalls associated with using hypnosis for this purpose (see Lynn, Lock, Loftus, Krackow, & Lilienfeld, in press). However, if therapists do treat traumatized clients with continuous memories of trauma or abuse, they need to exercise special caution regarding the wording and implications of their suggestions with high and medium hypnotizable subjects, taking particular care to monitor the therapeutic
proceedings for any contamination by suggestive influences. At the same time, due caution is warranted with low hypnotizable persons as well. It is worth noting that psychotherapists might wish to test for hypnotizability even when nonhypnotic procedures are used because medium and high hypnotizable individuals evidence relatively high rates of pseudomemories in nonhypnotic conditions as well as hypnotic conditions (see McConkey, Barnier, & Sheehan, 1998).

Not all clients can benefit from hypnotic treatment (Wadden & Anderton, 1982; Brown, 1992). For instance, obsessive-compulsive patients are less hypnotizable than both other patient groups and normal controls (Spinhoven, Van Dyck, Hoogduin, & Schap, 1991). Of course, clients with little or no hypnotic ability may be better served with nonhypnotic treatments (Bates, 1993).

However, Lynn and his colleagues (Lynn, Kirsch, Barabasz, Cardena, & Patterson, 2000) have observed that many hypnotic interventions require little special hypnotic or imaginative abilities and, instead, rely on relatively easy suggestions (e.g., guided imagery, relaxation, imaginative rehearsal) that the majority of the population can successfully pass. Accordingly, extreme hypnotic suggestibility may not confer any particular benefit on a client, whereas relatively low levels of hypnotic responsiveness would not necessarily preclude successful responding to therapeutic suggestions. In short, the reliance on relatively “easy” suggestions in a given treatment would be expected to attenuate correlations between measured hypnotizability —which entails assessment of a broad range of suggestions that vary in difficulty— and treatment outcome. Whereas it is important to identify whether a client has the minimal hypnotic abilities necessary to comply with treatment suggestions, a high level of hypnotic suggestibility may not be necessary for an individual to achieve a positive therapeutic outcome.

Considerations in Assessing Hypnotizability

Let us assume for a moment that a decision is made to assess hypnotizability. How should the clinician proceed? Ordinarily, it is best to broach hypnosis as a treatment modality after a positive therapeutic alliance has been established and the client feels safe and secure in the relationship. One of the benefits of using hypnotic techniques is that the mere mention of the word hypnosis heightens treatment expectancies of success in many clients. Kirsch, Montgomery, and Sapirstein’s (1994) meta-analytic study showed that simply labeling a technique as hypnotic facilitated gains in cognitive-behavioral treatment approaches (see also Schoenberger, 2000). Also, in many of the disorders in which hypnotizability has been linked with treatment outcome, an association between positive motivation to change and treatment success has been identified (Bates, 1993). Relatedly, Kirsch (1991) has argued that therapeutic benefit may derive as much from positive treatment expectancies as hypnotic ability. This implies that whatever role assessment plays in treatment it must at least preserve, if not enhance, positive treatment expectancies and motivation.

To accomplish this end, hypnosis assessment ought to be fully integrated in treatment, with a fitting rationale attached to the procedure. Frankel and Orne (1976) have recommended that the client be told that the purpose of standardized testing is to tailor the individual’s treatment more effectively. In Frankel and Orne’s (1976) words, the client is told: “Knowing how you respond will enable us to modify the technique
so that it can fit in with the needs of your treatment.” (pp. 1259-1260)

As an initial assessment of potential responsiveness, particularly with clients who are reserved about experiencing hypnosis, clients can be introduced to hypnotic-like experiences such as the Chevreul pendulum\(^1\) (see Bates, 1993) prior to hypnosis. These demonstrations are simple, powerful, and increase the client’s expectations of responsiveness in other situations defined as hypnotic (Kirsch, 1994; Kirsch, Lynn, & Rhue, 1993). Of course, if the client continues to express reservations about hypnosis or finds responding to suggestion aversive, for some reason, the therapist and client may decide to pursue alternative nonhypnotic treatment methods. Hypnotic-like techniques can easily be redefined as relaxation or imagination with truly low hypnotizable clients.

Other procedures like those recommended by Kirsch and his associates (Kirsch et al., 1993) provide relatively fail-safe assessment possibilities. These authors suggest the use of simultaneous suggestions for heaviness in one arm and lightness in the other as a way of determining client responsiveness during an initial induction. If there is any overt response to the lightening suggestion (e.g., fingers twitching, arm movement), then further suggestions for lightness can be given. If there are no overt signs of response to lightness suggestions, then suggestions for increased heaviness are pursued. Responses to lightness suggestions may be an indication of a higher level of responsiveness, and can be followed up by more difficult suggestions. Whether or not the client responds to lightness suggestions, a gross measure of responsiveness is gained, while at the same time avoiding any sense of failure on the part of the subject.

Yet another approach is to administer a variety of suggestions in a waking context. Many studies (see Spanos, 1986; Lynn, Mare, Kvaal, Segal, & Sivec, 1994) indicate that task motivated or relaxed participants who are asked to think and imagine along with suggestions while awake can respond successfully to a variety of suggestions (e.g., hypnotic dreams, age regression, hand levitation, trance logic, and analgesia). If clients succeed in responding to these sorts of suggestions while awake, it is highly likely that they will respond to equivalent suggestions during hypnosis, unless they have particularly negative attitudes about hypnosis. However, if clients do not respond to such suggestions while awake, a number of options are available to the clinician. The clinician could either pursue an alternate nonhypnotic treatment approach, or could imply that the procedures did not work because the client was not hypnotized and re-test responsiveness to the test suggestions during hypnosis. Taking this latter course of action would, of course, be somewhat risky, and would depend on the clients’ expectancies and motivations concerning hypnosis.

---

\(^1\)A Chevreul pendulum consists of a thread or light string approximately the length from elbow to fingertips, with a bob such as a key attached. The person rests the elbow on the resting surface and holds the loose end of the thread between the thumb and forefinger, with the wrist bent at approximately a right angle. The person is given instructions to focus on the bob and to think of the bob doing different things, such as making circles or swinging back and forth in predetermined directions. Clients’ commonly reported experience is that the pendulum moves in conformity with the imagined or suggested movement but without awareness of intentional physical movements of the hand or arm. The experience can easily be self-generated without external suggestions.
If therapists require additional information about clients’ responsiveness, they must decide whether to use formal, standardized tests of hypnotic responsiveness, or to use nonstandard tests of responsiveness carefully tailored to the treatment at hand (Bates, 1993). If the clinician decides to use a standardized test, then he or she must further decide about whether to use a relatively long test of hypnotizability or a shorter yet potentially diagnostic assessment of hypnotizability such as the Hypnotic Induction Profile (HIP; Spiegel & Spiegel, 1978).

Two sensible choices for a short yet informative multidimensional assessment are the Hypnotic Induction Profile (Spiegel & Spiegel, 1978) and the Stanford Hypnotic Clinical Scales of Morgan and Hilgard (1978-1979, 1978-1979b), which provide scores for both adults and children in less than 15 minutes. Barabasz and Barabasz (1992) as well as Nadon and Laurence (1994), strongly recommend the much longer Stanford Hypnotic Susceptibility Scale, Form C (SHSS:C; Weitzenhoffer & Hilgard, 1962) or a tailored version (Hilgard, Crawford, Bowers, & Kihlstrom, 1979) “primarily because of its stringency and its broad sampling of hypnotic suggestions” (p. 91). The advantage of a tailored version is that it can provide information about specific responses relevant to treatment. However, the SHSS:C frequently takes more than an hour, thereby limiting its use in many clinical situations. The SHSS:C has more “top” due to the greater number and difficulty of items, making it essential for interventions that require high levels of hypnotic involvement (e.g., hypnosis as the sole anesthetic for surgical procedures for whom general anesthesia is contraindicated). If treatment is brief and involves only relaxation or generic ego-strengthening suggestions, a thorough assessment of hypnotizability and an examination of responses to a variety of suggestions may not be required. If the therapist knows in advance which suggestions will be relevant to treatment, he or she may decide to limit hypnotizability testing to specific, treatment-relevant target suggestions. It may not be essential to test clients on a complete hypnotizability scale if the clinician is only interested in determining the robustness of hypnotic amnesia, for example, or how a person might respond to an age regression, analgesia, or hypnotic dream suggestion. However, in many, if not most cases, we recommend that formal assessment should be conducted on a routine basis. Furthermore, standardized measures are required in research settings or when the need to report clinical studies or an individual case study is anticipated. When in doubt, the clinician’s dictum should be: “test.”

Because there is a great deal of variability in how even high hypnotizable individuals experience and respond to suggestions, a high hypnotizability score does not obviate the need to evaluate clients’ responses to specific suggestions that are germane to treatment. Given that hypnosis is a multidimensional experience, it is useful to assess not only observable hypnotic responses, but also the degree to which the client is engaged at the cognitive, affective, and relational level. After all, most clinicians are as keenly interested in the client’s internal, or subjective experience of suggestion as they are in the client’s ability to enact a behavioral response, such as hand levitation, in keeping with a suggestion.

A number of the commentators we referred to at the outset of the article noted that sensitive measures of subjective experiences, processes, or rapport with the hypnotist were not available. Whereas that observation might have been valid in the past, it is no longer valid. Scales of suggestion-related involvement and involuntariness have been added to standardized hypnotizability scales, and there are excellent measures
of relational processes in hypnosis and subjective experiences. These include Nash and Spindler’s archaic involvement measure (AIM, 1989), Pekala’s measures of states of consciousness, (Pekala, 1991, 2002; Pekala & Kumar, 1984), and Spanos and his associates’ Resistance Toward Hypnosis Scale (Spanos, Cross, & deGroh, 1987). Furthermore, videotape interview technologies have been developed, including the Experiential Analysis Technique (see Sheehan & McConkey, 1982), which permit a window to the client’s moment-to-moment experience of hypnosis and identify individual cognitive styles (i.e., constructive, concentrative, independent, Sheehan & McConkey, 1982) germane to responsiveness to suggestions. In short, extant instruments with excellent psychometric properties make it possible to conduct a thorough and comprehensive assessment of a client with regard to salient and clinically meaningful dimensions of hypnosis.

Some of the commentators’ remarks we cited at the outset implied that the clinical context itself may distort participants’ responses to assessment measures, rendering their relevance to treatment questionable. For instance, factors such as resistance may be more evident in the clinical than the experimental setting (Spinhoven, Vanderlinden, Kuile, & Linssen, 1993). Two studies by Spinhoven and his colleagues bear on this issue. In the first study, Spinhoven and Van Wijk (1992) evaluated the experiences of age regression among a group of psychiatric hospital day patients in a research setting and with their own therapists in a clinical setting. They found that a greater percentage of the patients experienced age regression in the clinical setting and rated their experiences as more real in the clinical setting. Hence, rather than detracting from hypnotic involvement and responsiveness, the clinical setting appeared to promote it: assessment of hypnotizability in an experimental context may thus provide a conservative estimate of responsiveness in a clinical context.

In a second study of 99 psychiatric patients with the Stanford Hypnotic Clinical Scale for Adults, Spinhoven and his colleagues (Spinhoven, Vanderlinden, Kuile, & Linssen, 1993) concluded that the effects of resistance in clinical situations is modest and that standard hypnotizability assessments are similar in their meaning in an experimental and clinical context.

In summary, hypnotizability assessment can provide the clinician with a wealth of data relevant to hypnotic and nonhypnotic treatment. Many of the reservations expressed by the commentators noted at the beginning of this article can be addressed by the sensitive application of assessment procedures in a variety of clinical contexts. Although each therapist must weigh the costs and benefits of any assessment procedure with each client, we would argue that some form of assessment of hypnotizability, whether formal or not, can be useful with many clients who are treated with hypnotic and nonhypnotic interventions.

References
The Role of Hypnotizability Assessment in Treatment


The Role of Hypnotizability Assessment in Treatment

Hypnosis, 37, 85-94.


