Operationalizing Trance II: Clinical Application Using a Psychophenomenological Approach

Ronald J. Pekala
Coatesville Veterans Administration Medical Center

Although many clinicians use the word “trance” to describe the subjective effects associated with being hypnotized, heretofore there has been no means to operationalize that concept. In a prior paper (Pekala & Kumar, 2000) the authors operationalized the notion of trance by using a retrospective, self-report instrument, the Phenomenology of Consciousness Inventory (PCI), to quantify the subjective experience of being hypnotized. Trance was operationalized in terms of: hypnotic depth via a pHGS (predicted Harvard Group Scale) score (derived from regression analysis using subdimensions of the PCI) that gives a quantitative measure of subjective trance depth; and trance typology profiles (derived from cluster and discriminant analyses of the PCI dimensions and subdimensions) that give a qualitative measure of empirically derived clusters of subjective trance experiences. These measures, when used in conjunction with data on the individual PCI dimensions and subdimensions, provide the clinician with specific information on phenomenological events experienced by the client during hypnosis which can be used in better adapting hypnotic suggestions to the client’s phenomenological world. Two clinical cases are presented in which use of the above approach has been helpful in facilitating treatment planning.

Hilgard, one of the originators of the Stanford Scales (Weitzenhoffer & Hilgard, 1959, 1962), regarded assessment as crucial for providing a scientific basis for therapy:

The characteristic of an unscientific therapy is that there is only one disease and only one cure: such therapies imply that everyone can profit from the favored therapy regardless of the presenting problem. A scientific therapy is based on a diagnosis, which in psychotherapy

This paper is based, in part, on an Invited Plenary Address (Pekala, 1999, March) given to the American Society of Clinical Hypnosis during the ASCH Annual Meeting in Atlanta, GA. A longer version of this paper, with two additional clinical cases, is available from the author upon request. The author wishes to thank V. K. Kumar, Ph.D. and two anonymous reviewers for their helpful comments on an earlier version of this paper. The author wishes to acknowledge Dr. Ulrich Ott for writing an EXCEL version of the PCI-HAP SYSTAT program. Request reprints from:

Ronald J. Pekala, PhD
Biofeedback Clinic (116B)
Coatesville VA Medical Center
Coatesville, PA 19320.
means selecting the therapy of choice appropriate to fit the patient’s condition. Hypnosis is only one of these choices, and its choice and the manner of its use can profit from some estimate of the individual’s hypnotic responsiveness. (Hilgard, 1982, p. 400)

Given the current constructivist approach to therapy (Neimeyer, 1993; Neimeyer & Mahoney, 1999) and the need for developing an eclectic, time-limited approach in HMO environments (Hersen & Biaggio, 2000), many clinicians are increasingly concerned about tailoring treatments to the client’s personality, dynamics, and stage of change (Prochaska, 1995; Prochaska, Norcross, & DiClemente, 1994). Such an eclectic approach to therapy tailors the treatment to the client’s stage of motivation for change, and takes into account individual differences factors in promoting change. As Hilgard suggested, one’s hypnotic ability is one such individual differences factor.

**A Psychophenomenological Approach to Operationalizing “Trance”**

Pekala (1995a, 1995b) has previously reported on an approach to measure hypnotizability unobtrusively, via a self-report questionnaire called the Phenomenology of Consciousness Inventory (PCI, Pekala, 1982, 1991c). The PCI is a 53-item self-report inventory completed retrospectively in reference to a short stimulus interval. This approach to measuring consciousness in general, and hypnotizability in particular, has been dubbed a psychophenomenological approach since “it seeks to describe the phenomenological contents of consciousness as do the phenomenologists, a la Husserl (1913/72), and psychological in the sense of using traditional psychological and statistical approaches to do this.” (Pekala, 1991b, p. 5)

The approach involves completing the PCI retrospectively in reference to a sitting quietly period embedded in a hypnotic intervention. Subjective experience is measured according to the 26 dimensions and subdimensions of the PCI. Hypnotizability is quantified in terms of a hypnotic depth score using a regression equation of the PCI dimensions and subdimensions, developed in prior research (Pekala & Kumar, 1984, 1987). The regression equation generates a predicted Harvard Group Scale (pHGS) score that usually ranges between one and nine, and correlates about .60 with the Harvard (Forbes & Pekala, 1993; Pekala & Kumar, 1984, 1987).

More recently, hypnotic experience has been assessed qualitatively in terms of trance typology profiles (Forbes & Pekala, 1996; Pekala, 1991a; Pekala & Forbes, 1997; Pekala, Kumar, & Marcano, 1995). Subjects’ experiences during hypnosis were assessed with the PCI, and the dimensions of the PCI were cluster analyzed to determine if there may be different “types” or subclusters of individuals who report differing types of subjective experiences during hypnosis. The results of these four studies, summarized in Pekala and Kumar (2000), suggested that there were certain prototypical groups of subjects who reported qualitatively different subjective experiences during hypnosis. Drawing upon discriminant analysis (Pekala & Forbes, 1997), the unstandardized discriminant function coefficients are calculated that determine (via the discriminant function coefficients) which particular “type” of hypnotizable individual a person might be.

Kirsch and Lynn (1995) acknowledge that one of the difficulties with understanding the hypnotic process concerns the definition and operationalization of
trance: “without some means of determining whether a person is in trance, it is impossible to test any hypotheses about the effects of trance” (p. 489). Use of both the pHGS scores (to obtain a quantitative measure of hypnotic depth), and trance typology profiles (to generate a qualitative measure of trance type), allows the researcher and clinician to define and operationalize trance.

Besides measuring depth and quality of trance, the individual PCI dimensions and subdimensions allow the clinician to “sample” the phenomenological experiences that the client reports during a sitting quietly period within the hypnotic assessment/intervention. Use of this information, in conjunction with an estimate of the level of hypnotic depth achieved by the client and the client’s particular hypnotic type, allows the clinician to make an more informed decision, in collaboration with the client, for devising an efficacious treatment plan for using hypnosis within the therapeutic encounter.

The PCI-HAP

Several years ago the PCI was incorporated into a “hypnotic assessment procedure” called the PCI-HAP (Pekala, 1995a, 1995b). The PCI-HAP consists of relaxation instructions called a “body scan” (progressive relaxation instructions but without the tensing), a hypnotic induction procedure called a “mind calm” (counting from “10” to “1” while suggesting that the mind become calm and empty), a suggestion to have a vivid hypnotic dream, an eye catalepsy item, and a 2-minute sitting quietly period embedded near the end of the induction procedure. The clinician completes a short debriefing form immediately after the hypnosis. For this debriefing, clients rate the vividness of their imagery during the hypnotic dream, indicate whether they opened their eyes during the eye catalepsy item, and answer a few other questions. The client then completes the PCI retrospectively (after the therapy session) in reference to the sitting quietly period embedded in the hypnosis.

The PCI-HAP is used as a means to introduce the client to hypnosis but also allows the clinician to get a measure of the client’s hypnotic potential via his or her pHGS score and hypnotic profile type. Additionally, the PCI provides a measure of how reliably the participant completed the inventory by means of five pairs of reliability items embedded in the PCI. A reliability index (RI) score greater than 2.0 is considered unreliable (Pekala, 1991b).

Most clinicians usually have a standard hypnosis routine that they use to introduce the client to hypnosis. The PCI-HAP is no different in this respect, except for the fact that valuable data on the client’s phenomenological experiences during hypnosis are obtained. Whereas the PCI-HAP induction takes about 20 minutes to complete, completion of the debriefing form (whether therapist- or self-administered) takes about 5 minutes. The client will take another 10 minutes to complete the PCI, and it takes about 2 minutes to type in the numbers in EXCEL or SYSTAT to generate a PCI-HAP profile. (see Pekala, 1995a, 1995b, for a more in-depth review of the PCI-HAP in terms of development and clinical application.) The PCI is scored with either

---

1Copies of the PCI, the PCI-HAP, and the therapist and self-report debriefing forms are available by writing to the author.
a SYSTAT and EXCEL program that generates the following: a RI (reliability index) score; a pHGS (predicted Harvard Group Scale) score; a trance typology profile, and graphs of the raw scores and percentile scores for the 12 major and 14 minor PCI dimensions.

**Reasons for Nonassessment of Hypnotizability and the PCI-HAP**

Most clinicians do not measure hypnotizability when they see a client due to a variety of reasons (Cohen, 1989). These include the belief that assessment is not necessary, that is, everyone can be “hypnotized;” that an assessment may detract or hinder the establishment of therapeutic rapport and success; or that if the assessment finds the person to not be very hypnotizable, a negative expectancy effect will bias the client against hypnosis (Barber, 1989; Diamond, 1989; Rossi, 1989). There are, however, clinicians, who do hypnotic assessments and believe them helpful (Spiegel, 1989; Spiegel & Spiegel, 1978). In summarizing the debate, Mott (1989) suggested that what is needed is not the avoidance of assessment of hypnotic talent, but rather “better and less intrusive ways to assess the capacity for hypnotic experience” (p. 2).

Concerning expectancy (Kirsch, 1991, 2000), and specifically, negative expectancy, clinicians do not want the client to feel that they are less hypnotizable than what they may actually be. Since most behavioral hypnotic assessments usually give the client some idea as to how hypnotizable they are (depending on how many items they pass or fail), clinicians omit such a formal assessment in case a low score suggests that the client is not (that) hypnotizable, when in fact they may actually be more hypnotizable than the testing suggests. (See Pekala & Kumar, 2000, for evidence to support this concerning “pseudolows:” individuals who score in the low hypnotizability level on the Harvard, but in the moderate hypnotizability level, phenomenologically.)

However, research by Pekala, Kumar, and Hand (1993) suggests that there is not a simple linear relationship between expectancy and how hypnotized one is; there is rather an interaction between hypnotizability and expectancy. In a study that first assessed expectancy to be hypnotized, followed by an actual hypnotic induction, subjects who believed they would have subjective effects consistent with not being that hypnotizable, were more likely to be non- or only mildly hypnotizable, as measured by the Harvard Scale. “High susceptibles, on the other hand, underestimated the alterations in subjective experience that they expected to experience during hypnosis ...“ (p. 141), meaning that the actual subjective effects high hypnotizables experienced under hypnosis were greater than what they had expected prior to the hypnotic intervention, and opposite to that of the lows. The above research suggests that it is not only a hypnotic assessment, if a client does not perform well, that may lead to negative expectancy and hence poor performance, but rather a prior expectancy of not being hypnotizable (without any prior experience of hypnosis whatsoever), that may result in a self-fulfilling prophecy, leading to poor performance.

---

A copy of the EXCEL version of the program (5.0, 97, and 2000) for scoring the PCI-HAP is available from the author by e-mailing to: pekalar@voicenet.com. A copy is also available from Ulrich Ott at the Center for Psychobiology and Behavioral Medicine at the University of Giessen, Giessen, Germany. The Excel program can be downloaded from his URL by typing: [http://www.psychol.uni-giessen.de/mitarbei/ott/research/PCI1easy.zip](http://www.psychol.uni-giessen.de/mitarbei/ott/research/PCI1easy.zip).
Many clinicians feel that failure to pass behavioral items on a hypnotic assessment will suggest to clients that they are not that hypnotizable. In this regard, the PCI-HAP was developed to be unobtrusive. It has only two “objective” items, the hypnotic dream item and the eye catalepsy item (Pekala, 1995a). Additionally, the client’s pHGS score is a function of 10 PCI dimensions and subdimensions. The client is less likely to feel he “failed” the assessment, based on his completion of these items, since there are less “clear cut” criteria of what success or failure may be on these PCI items. Finally, the distribution of pHGS scores is negatively skewed. Two-thirds of clients will score approximately 5 or above (on a 1 to 9 scale) on the assessment (moderately to highly hypnotizable range), and only 10% will score in the unhypnotizable or only mildly hypnotizable range (a score less than 3) based on norms provided by Pekala (1991b, pp. 376-379) when the PCI was completed in reference to a sitting quietly period embedded in the Harvard. Hence, clients at the 33rd percentile of the distribution are given a (middle) score of about 5 on a 1 to 9 continuum, which would tend to create a more positive expectancy towards subsequent hypnotic interventions, than if they were labeled a 3.

Another reason clinicians do not assess hypnotizability is due to the belief by the clinician that if the client tests out as not very hypnotizable, having been disappointed in their non- or low hypnotizability level, clients will feel that there is “nothing else” that can be done for them, become demoralized, and possibly drop out of therapy. It is true that clients who want to be hypnotized and find out that they are not very hypnotizable are usually mildly to moderately disappointed. But this can happen not only in the assessment phase but in the treatment phase as well. How many times have clinicians who don’t use an assessment done a hypnotic intervention, only to have the client tell them afterwards that they “didn’t go under?” Although a few clinicians may “reframe” the intervention and tell the client “that is exactly what I expected,” many clinicians are usually not comfortable with this type of reframe.

Of course, if no actual assessment of hypnotizability level is done before a treatment intervention, the client may not have a good idea as to how hypnotizable they actually are, because there are no salient cues to inform them of such. Some clinicians believe that without the clients’ knowledge of their actual hypnotizability level, positive expectancy effects and placebo effects will engender positive therapeutic outcomes, regardless of hypnotic ability. Although this may be true with some clients, I believe it is better to have knowledge about a person’s hypnotizability level and tailor a treatment plan to that level, instead of hoping that positive expectancy effects will do the rest.

Finally, it is not true that nothing else can be done for clients of low or very low hypnotizability level. If the issue is one of stress management and the client does not test out to be that hypnotizable, the clinician can usually move the client into biofeedback (Basmajian, 1989) using electromyographic, skin temperature, and skin conductance modalities to help with stress reduction, in addition to more cognitive-behavioral approaches (McDermott & Wright, 1992). This is consistent with the

---

1A recent modification has added an ideomotor item to assess if the client fell asleep during the hypnotic assessment (see “Use of trance typology profiles . . .” below).
research and theorizing of Wickramasekera’s (1988, 1997, 1999) “high risk model” for using biofeedback strategies with low hypnotizable clients. If the issue is one of trauma reduction, the clinician can use EMDR (Shapiro, 1995; Shapiro & Forrest, 1997) or flooding.

Use of Trance Typology Profiles in Tailoring Hypnotic Interventions to the Client

Besides using the pHGS score to get a measure of hypnotic depth, the profile of discriminant function coefficient scores in the trance typology profile (see Figure 1) allows the clinician to get an idea as to which “type” or “types” the client tests out to be. I use the typology information to further refine tentative hypotheses concerning the “type of trance” the client may be experiencing. (See Pekala and Kumar, 2000, for a more in-depth review of trance typology profiles.)

As an example, suppose two clients obtain a pHGS score of 3.5 on the pHGS score, but one is a “classic low” and the other a “relaxed low.” These two types, despite their identical depth scores, have rather different phenomenological responses to hypnosis. While the relaxed low typically will report a relaxation of muscular tension during hypnosis (but little alterations in subjective experience or state of awareness), the classic low has a paradoxical response to hypnosis and actually gets more muscularly tense (at least subjectively experienced) during hypnosis than had he just sat quietly with his eyes closed. I have usually had little initial success in using hypnosis with classic lows. Classic lows don’t like to be hypnotized and will usually tense up subjectively under hypnosis. With classic lows I usually find myself employing progressive relaxation (the client has the self-control by tensing or relaxing their muscles) or biofeedback (which has an ostensible self-control methodology associated with it). In contrast, relaxed lows can usually relax with hypnosis as much as other relaxation exercises. However, relaxed lows usually cannot benefit as much from hypnotic or post-hypnotic suggestions as can the more highly hypnotizable types.

As another illustration of the usefulness of the profiles, let us suppose that two clients have obtained a pHGS score of 5.0, but one is a “visualizer,” and the other, a “dialoging medium.” I typically mentally add a point to the client’s pHGS score if they are a visualizer, because the pHGS score appears to underestimate the hypnotic depth (usually associated with a more positive treatment response) of visualizers. Hence, I tend to view a visualizer with a pHGS score of 5.0 as having a pHGS score of about 6.0. Dialoging mediums with a pHGS score of 5.0, on the other hand, are not as hypnotizable as the similarly scoring visualizers. Additionally, they usually need to practice self-hypnotic strategies more than visualizers, probably because the internal chatter makes it somewhat harder for the dialoging mediums to become as easily absorbed in hypnotic suggestions as the visualizers. (Although visualizers also appear to have a more internal chatter than most other types, this is less of a problem for them than the dialoging medium type, possibly because it is counteracted by the visualizer’s higher imagery involvement.) Affirmations --that is, verbal (nonimagoic) suggestions-- are utilized more with the dialoging types (both the dialoging mediums and high-mediums), since visual imagery may be low, and such verbal suggestions are congruent with the already occurring internal monologue.

Mention should also be made of the “classic highs.” Although they make up about 12% of the experimental population (see Table 5, Pekala & Kumar, 2000) I
have yet to assess one of these types in my private practice. I have the suspicion, recently supported by anecdotal data (Pekala & Kumar, 1999), that some or many of the classic highs may have fallen asleep (or moved in and out of sleep) during the Harvard Group Scale (Shor & Orne, 1962) assessments. Because of the group administration, no effort was made to awaken the participants if they fell asleep (and hence they would have completed the PCI in reference to that sleeping period). However, in my private practice, if a client falls asleep I do not have them complete the PCI afterwards.

For this reason, the debriefing form (both therapist administered and self-scored), along with the PCI-HAP protocol, have been slightly modified to include an ideomotor signaling item and verbal report (as per the debriefing form) to determine if the client/participant may have fallen asleep during the assessment. In a study currently in progress (Pekala & Kumar, 1999), the one person who tested out to be a classic high on the PCI appeared to have fallen asleep during part of the hypnosis protocol.

In addition to using the PCI-HAP assessment results to determine the feasibility of integrating hypnosis into the treatment plan (and determining how best to implement hypnotic strategies), use of this approach can also be helpful in informing the client as to their need to practice a self-hypnosis tape that is made for them within the session. (Most of the time, I will record for the client a self-hypnosis tape addressed to their particular problem or concern, which they then practice outside the office.) If a person tests out to be mildly to moderately hypnotizable, clients usually need to practice self-hypnosis tapes more often, and more consistently, than a person who is highly hypnotizable. By measuring hypnotizability, we can give the client an idea as to how often they will need to practice, in addition to how short or long we will need to make the tapes.

**Case Illustrations for Using the PCI and Its pHGS Scores, Trance Typology Profiles, and PCI (Sub)dimension Graphs**

Computer programs have been developed with SYSTAT (Wilkinson & Hill, 1994) and EXCEL (Blattner, Ulrich, Cook, & Dyck, 1999) that graphically illustrate the nine hypnotic types along with scores for the different PCI dimensions and subdimensions. The printout not only illustrates the client’s trance typology profile and the client’s estimated hypnotic depth score (the pHGS score), but it also provides useful information on the client’s subjective experiences during the hypnotic intervention via graphs of the scores of the various PCI dimensions and subdimensions. Although the present paper only illustrates the PCI dimension and subdimension raw scores, the SYSTAT and EXCEL programs generate not only the raw score profiles but also percentile graphs of all PCI dimensions and subdimensions. Two clinical cases are reviewed below which use this approach in developing and implementing treatment plans.

**Joey**

Joey is an adolescent client who was suffering flashbacks due to his father’s unexpected death from a heart attack. The father had died approximately six months ago. Joey was quite attached to his father and was the father’s “best friend.” They went to all sporting events together. Joey suffered flashbacks of his dad, having witnessed his father’s death. Joey had an argument with his dad the night before he
passed away, and felt somewhat responsible for his father’s death. Joey was also angry at relatives who did not attend his father’s funeral. He was diagnosed as having PTSD symptoms in response to witnessing his father’s death.

Since his father’s death, Joey felt depressed, lonely, and lost. His mother was afraid that her son might have schizophrenia since he was experiencing hallucinations (extremely vivid flashbacks) of his father. A hypnotic assessment with the PCI-HAP indicated that Joey was in the highly hypnotizable range. He obtained a pHGS score of 7.20 (with a RI score of 0.60); pHGS scores of greater than 7 are considered in the highly hypnotizable range (Pekala, 1991b). But Joey was also a visualizer, or a “5,” as illustrated on the trance typology profile of Figure 1 (the scales can be numbered from 1 to 9, left-to-right, with each particular number corresponding to one of the nine types).

Joey was capable of having very vivid imagery even when not hypnotized. I believe Joey was prone to vivid flashbacks not only due to the unresolved affect associated with his father’s untimely death, but also due to his extremely vivid imagery. This information was helpful in explaining to the client’s mother that her son was not “schizophrenic;” rather, he had a visualization ability that made him especially prone to flashbacks of hallucinatory intensity.

Figures 2 and 3 illustrate Joey’s PCI scores of the major and minor PCI dimensions, respectively. During the sitting quietly period embedded in the PCI-HAP, Joey obtained the maximum score on visual imagery (“6” out of “6”), despite the fact that there were no suggestions to have imagery during this time; y-axis scores run from “0” (little or none) to “6” (much or complete). Although there was a large drop in volitional control, there were almost no drops in rationality or memory, and a great deal of internal dialogue. (Visualizers typically do not report the usual drops in rationality, memory, and self-awareness typically associated with being highly

![Figure 1: Joey: Trance Typology Profile](image)
hypnotizable - see Pekala and Kumar, 2000.) Figure 3 shows that during this sitting quietly period embedded in the PCI-HAP there was some positive affect, but also substantial negative affect. The very high scores for anger, sadness, and fear were due to Joey thinking about and imagining his father’s untimely death during the hypnosis.

Joey was seen for a total of 19 sessions of hypnosis, EMDR (Shapiro, 1995), and supportive therapy for the loss of his father, his flashbacks, and additionally, for his poor grades. Using the PCI-HAP results, a hypnotic intervention was implemented that relied heavily on visual imagery and a “trip to heaven” (Joey was Catholic) to help assuage and resolve much of the affect associated with his father’s untimely death. During this hypnotic intervention, Joey met with his father at the “pearly gates” and asked him, among other things, why he had been taken away. The father explained that he had been called to fulfill his obligations in heaven. Additionally, Joey was able to apologize to his father for the argument that occurred the night before his death. This hypnotic dialogue appeared to “lay to rest” a host of unanswered questions for Joey and perhaps allowed Joey to obtain closure and begin to move on with his life. The hypnotic intervention was followed by EMDR for three different flashback scenarios that were upsetting Joey. The EMDR was effective in eliminating the flashbacks.

Figure 2: Joey: Intensity Scores: PCI Major Dimensions

Figure 3: Joey: Intensity Scores: PCI Minor Dimensions
I fortuitously met Joey and his mom at a local store about 9 months after therapy ended. His mom reported that Joey had made the honor roll. Although there was still some sadness at times related to the loss of his father, there were no flashbacks. He was even going to sporting events with his friends.

**Dave**

Dave is a 34-year-old male referred for difficulty falling asleep and maintaining sleep (sleep onset and early morning awakening insomnia), with PTSD symptoms concerning intrusive thoughts, rumination, and guilt. The client was a fireman. He had had several incidents where individuals and families that he had tried to rescue had had tragic deaths. One incident that was particularly traumatic concerned a family (mother, father, and three children) who died in a spectacular fire. A biofeedback psychophysiological assessment revealed very high muscle tension levels (20 to 30 microvolts - normal readings would be 1 to 3 microvolts) when just thinking about the fire associated with the deceased family.

Dave had a very difficult time relaxing; he was also quite overcontrolled and initially had little insight into the psychological issues that might be affecting him. The therapy started with biofeedback and moved into EMDR (Shapiro, 1995). The EMDR was helpful in pinpointing some of the trauma associated with his sleep disturbance (uncovering a traumatic incident that he had apparently repressed). The EMDR, however, did not significantly reduce his insomnia. Dave was interested in trying hypnosis for his insomnia, although he believed he was not very hypnotizable. I believed that his overcontrol would make it very difficult for Dave to “let go.”

A PCI-HAP was completed. Dave’s pHGS score was 3.88 (RI = 0.80). His hypnotic typology profile was a combination of a “classic low” and a “dialoging medium,” what I call a 1-4 type. (When the discriminant function coefficients generate very similar scores for two of the nine hypnotic types, the person is labeled a combination of those types.) Classic lows have a paradoxical response to hypnosis. They actually report more subjective tension than if they were just sitting quietly with their eyes closed. The dialoging medium features of Dave’s PCI-HAP suggested rather average hypnotic (phenomenological) effects but with the addition of moderate internal chatter. Although hypnosis with mediums usually has mild hypnotic effects upon the client, these were negated by the negative affect and high arousal levels of being a classic low, making it quite difficult for this client to let go and relax, let alone be hypnotized.

Dave’s vacation imagery during the PCI-HAP hypnotic dream (as assessed with the PCI debriefing form) was a 3 (on a 1 to 10 intensity scale), indicating low vividness of imagery. Figure 4 illustrates his subjective experiences during this initial hypnotic assessment. He reported only mild drops in self-awareness, volitional control, rationality, and memory, and only mild alterations in state of consciousness and altered experiences. Figure 5 lists his scores of the PCI subdimensions. Notice his high scores on fear and sadness (during hypnosis most clients and subjects have scores of less than 0.50). The fear score he reported was related to his feelings of loss of control he thought associated with the hypnosis, while his high score on sadness and love, were related to thoughts concerning a deceased grandfather; thoughts which “bubbled up” during the sitting quietly period during the hypnosis. The grandfather was to play a major role in subsequent therapy (and the hypnosis, I believe, was helpful in allowing
this information into consciousness). The PCI negative affect subdimensions are usually quite helpful in assessing any untoward effects that the client may experience during the hypnosis; negative effects which the client may not necessarily verbalize during the debriefing, but which tend to show up on the PCI. Also notice the low scores on both imagery amount and vividness. Visual imagery was not very useful to Dave; kinesthetic imagery was somewhat more so.

An insomnia self-hypnosis tape was recorded for Dave. Kinesthetic imagery employing a hot tub was used for deepening hypnosis and verbal affirmations and kinesthetic imagery were used in implementing the suggestions. His total hypnotic induction was about 40 minutes, as opposed to about 20 minutes for most people (clients that are only mildly hypnotizable according to the PCI-HAP typically need longer induction ceremonies). Dave felt that the self-hypnosis audiotape “tailor-made” for him had a mild effect on reducing his sleep disturbance.

This case illustrates using hypnosis with someone who was not very hypnotizable. The assessment suggested only mild hypnotizability and that is what Dave reported when practicing with the self-hypnosis tape; only mild relief of symptoms and continual difficulty letting go and relaxing. Because Dave was extremely motivated to try whatever strategies he could to decrease his sleep disturbance, I believe the
A combination of hypnosis, EMDR, and biofeedback was moderately helpful to him. A second hypnotic assessment, completed about 3 months after the first, revealed that although his hypnotic depth did not change, that is, his pHGS score was now 3.81, he tested out to be dialoging medium with no classic low involvement. There was much less muscle tension tightness (high arousal) and less fear associated with the hypnosis in comparison to the first hypnotic intervention.

**Conclusions**

The aforementioned clinical cases illustrate how information obtained with the PCI-HAP was subsequently utilized in therapy. I believe effective therapy tailors the client’s individual personality dispositions (Budman & Gurman, 1988) and dynamics (Groves, 1992) with treatment interventions aimed at the client’s level of motivation and stage of change (Prochaska, 1995, 1999), to help the client deal with particular symptoms and problems. The PCI helps with assessing hypnotizability depth and type. This information can then be used, along with the psychophenomenology as assessed by the PCI dimensions and subdimensions, to implement hypnotic strategies to make therapy more individualized, and more effective. By obtaining a measure of hypnotic depth and type and knowing which phenomenological processes are especially activated during hypnosis, i.e., vivid imagery, loss of control, time distortion, etc., the clinician can use that information, along with the client’s dynamics and personality (Millon, 1988) to generate hypnotic suggestions and content (Hammond, 1990, 1998) congruent with his or her phenomenological world.

**References**


Pekala, R. J. (1999, March). Are there different “types” of hypnotizable individuals? Rationale, research, and clinical application. Plenary address given to the American Society of Clinical Hypnosis at the Annual Scientific Meeting, Atlanta, GA.


