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AUSTRALIAN JOURNAL OF
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EDITORIAL

With this first edition for what I hope will be a productive year for the *Australian Journal of Clinical and Experimental Hypnosis*, I have an unhappy duty to perform. Dr J. Arthur Jackson has been forced by ill health to retire from the Society and from his position as Associate Editor with the journal. Arthur has been associated with the Society and the journal for many years and the journal, in particular, will miss his contributions and the role he has played as Associate Editor. He also made an outstanding contribution to the first of the anthologies published by the journal, with his chapter detailing the anxiety disorders and their treatment.

This edition includes a special Case Note from Arthur and Dr Lorna Channon-Little, which provides a fitting summary of his approach to hypnosis in therapy. On behalf of the journal and its staff, I wish him all the best for his retirement.

Clinical Update Papers

This year will see the introduction of another new feature to the journal. To increase its interest and usefulness to members, the journal will regularly publish Clinical Update Papers in areas of psychology, psychopathology, and general medicine. Working in clinical practice, it is often difficult to keep abreast of clinical and experimental developments in these fields and the focus of Clinical Updates will be to review current developments in the areas under consideration, to provide a quick summary of new trends and research.

The first of these Clinical Update Papers is published in this number of the journal. This is the article by Greg J. Coman and Barry J. Evans: "Clinical Update on Eating Disorders and Obesity: Implications for Treatment With Hypnosis."

Researchers and clinicians, within and outside the Society, will be asked to write Clinical Update Papers on their areas of expertise over the next twelve months.

Journal Anthology Series

By now you will be aware of and, I hope, will have purchased the first two anthologies in the series currently being published by the journal. Work is under way on the next two anthologies in the series.

By the end of 1995, the journal will have published *Hypnosis in the Treatment of Sexual Dysfunction* and *Hypnosis in the Treatment of Habit Disorders*. Treatment of a range of habit disorders is the major reason for referrals to members of the Society in the various states and sexual dysfunction remains a serious and widespread problem. I hope these two additions to the journal's collection will be of interest and value to you and will be supported in the way the first two anthologies have been.

Special Section: Hypnosis in the Management of Obesity and Eating Disorders

This edition of the journal features a special section devoted to an examination of the role to be played by hypnosis as an adjunct for treatment of obesity and eating disorders. It features three articles specially written for the *Australian Journal of Clinical and Experimental Hypnosis*.

Greg J. Coman and Barry J. Evans provide a review of the current literature on the eating disorders of anorexia nervosa and bulimia. The diagnostic criteria for both in the new *Diagnostic and Statistical Manual* of the American Psychiatric Association (DSM IV, 1994) are discussed, together with aetiological views for both disorders. Personality characteristics associated with both disorders are also discussed. The current literature on the epidemiology of obesity is presented and the finding that many of the so-called normal community have disordered eating attitudes and behaviours is reported. The article concludes with some general treatment issues with hypnosis when counselling those interested in weight management.

Elizabeth Georgiou presents an interesting case of anorexia nervosa in a 29-year-old woman, successfully treated using a multi-disciplinary approach to therapy, with hypnosis as an adjunct. This case illustrates that anorexia may be successfully treated using hypnosis, despite the reportedly lower hypnotisability of sufferers of anorexia.

In the final article in this special section, Rosalyn Griffiths presents her hypnobehavioural treatment program for bulimia. This is a detailed treatment regime, combining behavioural and hypnotic techniques, which has demonstrated effectiveness for the eating disorder, and which may have implications for therapy in almost all cases of weight counselling.

*Barry J. Evans
Monash University
May 1995*

A DISCRIMINANT ANALYSIS OF SOME FACTORS RELATED TO HYPNOTIC SUSCEPTIBILITY

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The aims of the present study were to examine the relationship between the Harvard Group Scale of Hypnotic Susceptibility: Form A and the Stanford Hypnotic Susceptibility Scale: Form C, and to examine the effects of gender, handedness, academic major, and therapy history on hypnotic susceptibility. Results suggested a strong correlation between the two scales. Only gender correlated with hypnotisability, with female subjects being higher in hypnotic susceptibility than male subjects.

The measurement of hypnotisability has grown in importance in recent years. For example, 28% of all doctoral dissertations on the topic of hypnosis during the 57-year period 1923-1980 dealt with hypnotic susceptibility. None of the decades of the '20s, '30s, or '40s produced a dissertation on the topic, and only three were written on the topic during the 1950s. However, beginning with the 1960s and continuing to the present, a marked increase occurred. There were 19 on the topic during the '60s, and 61 during the decade of the '70s (Clark, Hungerford, & Reilley, 1984), and 138 during the decade of the '80s.

The hypnotisable person is one who can set aside critical judgment and respond to make-believe and fantasy activities conveyed through hypnotic suggestions (Hilgard, 1965; Perry, 1977). This person can temporarily experience "alterations in perception, memory, or mood" (Orne, Whitehouse, Dinges, & Orne, 1988). While approximately 15% of the normal population is highly hypnotisable (Hilgard, 1965), 10% to 15% are almost completely unresponsive. The majority of persons are able to experience some, but not all, of the sensations which occur in a hypnotised condition. These experiences occur in varying degrees (Bernheim, 1889; Faria & de Abbé, 1906; Hilgard, 1965). The degree of a person's hypnotisability is a persistent and reliable trait which does not change much over time and across situations (Nash & Baker, 1984; Perry, 1977).

Subjects for research as well as for clinical applications are selected usually on the basis of their performance on a standardised measure of hypnotic susceptibility. Several instruments are available to the clinician/researcher for use in determining the hypnotisability of a subject. Three which are in widespread use are the Hypnotic Induction Profile (Spiegel & Spiegel, 1978); the Harvard Group Scale of Hypnotic Susceptibility: Form A (Shor & Orne, 1962); and the Stanford Hypnotic Susceptibility Scale: Form C (Weitzenhoffer & Hilgard, 1963). The Hypnotic Induction Profile test is a 10-minute scale that is administered individually to the subject. The test requires a rapid hypnotic induction administered by the researcher. During and following the trance, the researcher elicits subject self-reports of the experience. On the basis of those reports, the subject is regarded as being of either high, low, or moderate susceptibility.

The Harvard Group Scale of Hypnotic Susceptibility: Form A is a 50-minute test administered to a group of subjects simultaneously. The 12-item scale includes a hypnotic induction and, following the trance, subjects self-report on their experiences. Those subjects who score 0-4 on the 12-point scale are regarded as low susceptibility, those who score 5-7 are regarded as moderate susceptibility, and those who score 8-12 are regarded as high susceptibility (Pettinati, Kogan, & Evans, 1990).

The Stanford Hypnotic Susceptibility Scale: Form C is an *individually* administered 50-minute scale which requires a hypnotic induction. Unlike the Harvard Scale, the Stanford Scale is scored by the researcher/clinician during and at the end of the induction. This Stanford Scale "is generally regarded as the best available criterion of hypnotisability" (Register & Kihlstrom, 1986). Criteria for susceptibility for the Stanford Scale are the same as for the Harvard Scale.

The Harvard Scale: Form A has been reported to correlate significantly ($r=0.59$, $p<.001$) with the Stanford Scale: Form C (Evans & Schmeidler, 1966). However, most previous studies of their correlation have been with normal groups. Correlations between the Hypnotic Induction Profile and both the Harvard: Form A and the Stanford: Form C indicate that with special populations, such as schizophrenia subjects, significant differences exist (Pettinati et al., 1990)

Most of the studies of variables thought to be related to hypnotisability have investigated one, or relatively few, measures (Nadon, Lawrence, & Perry, 1987). Single measures typically indicate low correlations and, at best, moderate correlations, with susceptibility to suggestion (Sheehan & McConkey, 1982).

Efforts at finding correlates of hypnotic susceptibility frequently have produced negative findings and failure to replicate (de Groot, Gwyn, & Spanos, 1988; Hilgard, 1965; Spanos, 1982). One variable that has consistently predicted hypnotic susceptibility is absorption (Tellegen, 1979; Tellegen & Atkinson, 1974). Absorption refers to the degree to which subjects invest in imagination activities such as daydreaming, novel reading, and poetry (de Groot et al., 1988).

Several researchers (Hilgard, 1970; Spanos, Cross, & De Groh, 1987) have reported gender differences in susceptibility to hypnosis with correlations being higher for women than for men.

While no relationship between handedness and hypnotic susceptibility has been found (Wallace & Persanyi, 1989), there is some relationship between cerebral lateralisation and susceptibility (Bryden, 1982). Familial handedness appears to be related to hypnotic susceptibility. Subjects who had at least one left-handed relative exhibited significantly lower susceptibility than did those who had only right-handed relatives (Wallace & Persanyi, 1989). It also appears that there is a family relationship in hypnotic susceptibility. Subjects who scored low in susceptibility tended to come from families who had at least one other member who scored low; similarly, those who scored high also tended to have at least one relative who scored high (Wallace & Persanyi, 1989).

A significant negative correlation between assessed resistance to hypnosis and objective and subjective dimensions of hypnotic susceptibility was found by Spanos et al. (1987). The effect for symbiotic activation on hypnotic susceptibility was not significant (Frauman, Lynn, Hardaway, & Molteni, 1984). Schwartz and Burdsal (1977) found that sociability is a relevant part of hypnotic susceptibility. Hart, Norman, Brotman, and Payne (1983) found that one's ability to transfer from logical reality to creative imaginings was a cardinal element in hypnotic susceptibility and they further suggested that a multivariate approach would provide insights into hypnotic susceptibility. Frequent marijuana users (more than 10 times) showed greater susceptibility to hypnosis than did non-users (Franzini & McDonald, 1973).

The purposes of this study were two-fold: (a) to determine the relationship between the Harvard Group Scale of Hypnotic Susceptibility: Form A and the Stanford Hypnotic Susceptibility Scale: Form C in their assessment of subject's hypnotisability; and (b) to examine the extent to which hypnotisability could be determined by certain traits—specifically, gender, handedness, academic major, and therapy history.

Students enrolled at Auburn University during the 1991–92 academic year were asked to volunteer in a study to determine susceptibility to suggestion. A total of 282 subjects responded to the request and the scale was administered in six separate sessions over a period of six months. Each subject filled out a questionnaire on which they noted certain characteristics: their sex, age, grade point average, major, hand preference, whether they had been or were currently in therapy, and whether they had been hypnotised. In order to assure anonymity of the subjects, and to expedite a double-blind research design, each subject used a code designation, known only to them, as an identifier on all forms. The demographic data forms were reviewed by the research team and those subjects who had been, or who were currently, in therapy were interviewed by a clinical psychologist who then accepted or rejected that person as a subject. Two subjects were eliminated from participating because it was felt that their pathology might interfere or that the hypnosis might interfere with their therapy.

Table 1 summarises the demographic data for the overall sample as well as those classified as highly susceptible and those with lower susceptibility.

Table 1 Sample Demographics

Overall sample	(<i>N</i> = 280)	High susceptibility (<i>n</i> = 92)	Lower susceptibility (<i>n</i> = 188)
Gender			
Female	186 (66%)	68 (74%)	118 (63%)
Male	89 (32%)	22 (24%)	67 (36%)
Missing data	5 (2%)	2 (2%)	3 (2%)
Major			
Business	84 (30%)	26 (28%)	58 (31%)
Education	25 (9%)	8 (9%)	17 (9%)
Engineering	20 (7%)	1 (1%)	19 (10%)
Liberal Arts	106 (38%)	37 (40%)	69 (37%)
Nursing	11 (4%)	5 (5%)	6 (3%)
Science/Math	18 (6%)	7 (8%)	11 (6%)
Missing data	16 (6%)	8 (9%)	8 (4%)
Left-handed			
Yes	28 (10%)	8 (9%)	20 (11%)
No	232 (83%)	75 (82%)	157 (84%)
Missing	20 (7%)	9 (10%)	11 (6%)
Therapy			
Yes	32 (11%)	9 (10%)	23 (12%)
No	243 (87%)	81 (88%)	162 (86%)
Missing	5 (2%)	2 (2%)	3 (2%)
Average age	20.7	20.3	20.9
Average GPA	2.79	2.8	2.78

Note. Percentages may not total 100% due to rounding error.

The Harvard Group Scale for Hypnotic Susceptibility: Form A was then administered to each group. The instructions for administering the scale which accompany the test were followed verbatim. At the conclusion of the induction, each subject self-reported, on a 12-item scale, their experiences. Each scale was then scored and subjects were classified as being of low, moderate, or high susceptibility (0–4 low; 5–7 moderate; 8–12 high). The data were coded for computer statistical analysis so that each of the 12 items on the scale was denoted as well as the total score.

The subjects who were low or high were asked to further participate in the study. Since subjects were not told whether they were low or high, and since the researchers did not know if a specific subject had been scored as low or high,

the study was blind. An appointment was made for an individual induction with each subject who agreed to further participate. Two hundred and eighty subjects participated in this phase of the study.

Phase two subjects were then administered the Stanford Scale: Form C in an individual session. The individual measures were scored by the researcher during the actual induction. As with the Harvard Scale: Form A, the Stanford Scale: Form C was scored. Each subject had a total score as well as a score on each measure on the scale. There are six measures common to both the Harvard and Stanford scales.

METHOD

The internal consistency reliability of the 12-item Harvard Scale was estimated using Cronbach's alpha (α). This analysis resulted in a coefficient alpha of .91, providing evidence of the instrument's internal consistency.

The analysis of data occurred in three stages. First, a Pearson correlation was used to determine the statistical relationship between the Harvard Scale: Form A and the Stanford Scale: Form C. Second, a discriminant analysis was performed to identify those variables which could best be used to determine whether a person was susceptible to hypnosis. A person was classified as being highly susceptible to hypnosis upon reaching a score of 8 or above on the Harvard Scale. Hypnotic susceptibility was therefore grouped in two categories: (a) high susceptibility (8 or above on the Harvard), and (b) lower susceptibility (below 8 on the Harvard).

Four dependent variables were included in this analysis. These included gender, academic major, handedness, and previous therapy. The variables of gender, handedness, and previous therapy existed in dichotomous form. Academic major, initially recorded in categorical form, was criterion coded before it was used in the discriminant analysis. The demographic variables of age, grade point average, and previous hypnosis were not included due to a lack of variability. Follow-up univariate tests were then performed to identify the specific variables on which the two groups differed.

The third stage of analysis was conducted to further explain the effects of those variables identified as discriminating variables through the initial discriminant analysis. A multivariate analysis of variance (MANOVA) was used for this purpose. The 12 variables which comprise hypnotic susceptibility on the Harvard Scale served as the multiple dependent variables.

RESULTS

The results from Pearson procedure revealed a strong positive relationship. The findings ($r = 0.81, p < .001$) of the Harvard Scale: Form A (group induction), to the Stanford Scale: Form C (individual induction) support the earlier study of Evans and Schmeidler (1966; $r = 0.59, p < .001$) which also revealed a positive relationship between these two scales.

The results from the discriminant analysis are summarised in Table 2. The discriminant function resulting from this analysis was statistically significant ($\lambda = .9598$, $p = .039$). Follow-up univariate F -tests revealed that the determination of hypnotic susceptibility was made primarily on the basis of gender and academic major. Those individuals who were categorised as more susceptible to hypnosis were more likely to be female and have an academic major in the Colleges of Liberal Arts, Nursing, or Science and Math. Students having a major in the College of Engineering were least susceptible to hypnosis. Complete demographic information is summarised in Table 1.

Table 2 Summary of Discriminant Analysis Results

Variable	F	Significance
Gender	5.434	.0206
Academic major	4.544	.0340
Handedness	.129	.7193
Previous therapy	2.492	.1157

Univariate F -tests with (1,247) degrees of freedom
 Wilks lambda (λ) = .9598, $p = .039$

A two-group MANOVA was used to determine whether males and females differed on the 12 dependent variables of hypnotic susceptibility. These results are reported in Table 3. An overall multivariate difference between males and females was found (Hotellings $T^2 = .10696$, $p = .007$). Univariate follow-up F -tests were performed to identify specific differences between males and females. These tests of significance revealed that males and females differed significantly on 5 of the 12 Harvard items. Females were more likely to indicate signs of hypnotic suggestion on each of these items. Specifically, females indicated signs of their hypnotic suggestion on the following Harvard items:

- Item 3 — eyes closure
- Item 4 — left hand lowering
- Item 8 — hands moving together
- Item 9 — communication inhibition
- Item 11 — eye catalepsy

A six-group MANOVA was used to further investigate the effect of a major on hypnotic susceptibility. This analysis resulted in a nonsignificant Wilks lambda of .77180, $p = .284$. The effects of a major are somewhat confounded with gender as those students majoring in Engineering were predominantly male (70%) and those majoring in Nursing, Science and Math, and Liberal Arts were predominantly female: 82%, 76%, and 75% respectively.

Table 3 Comparisons of Males and Females on Hypnotic Susceptibility

Univariate <i>F</i> -tests with (1,273) DF					
Variable	Females	Males	Mean (SD)	<i>F</i> value	Prob.
	(<i>n</i> = 186)	(<i>n</i> = 89)			
Harvard 1	.409	(.49)	.427 (.50)	.083	.773
Harvard 2	.677	(.47)	.618 (.49)	.942	.333
Harvard 3	.677	(.47)	.517 (.50)	6.738	.010
Harvard 4	.796	(.40)	.562 (.50)	17.241	<.001
Harvard 5	.516	(.50)	.416 (.49)	2.434	.120
Harvard 6	.613	(.49)	.551 (.50)	.965	.327
Harvard 7	.645	(.48)	.584 (.49)	.949	.331
Harvard 8	.790	(.41)	.607 (.49)	10.639	.001
Harvard 9	.581	(.50)	.416 (.50)	6.679	.101
Harvard 10	.301	(.46)	.236 (.43)	1.263	.262
Harvard 11	.559	(.50)	.416 (.50)	5.009	.026
Harvard 12	.317	(.47)	.213 (.41)	3.201	.075

MANOVA: Hotellings $T^2 = .10696$, $p = .007$

DISCUSSION

The findings related to the correlation ($r = 0.81$, $p < .001$) of the Harvard Scale: Form A (group induction), to the Stanford Scale: Form C (individual induction) support the earlier study of Evans and Schmeidler (1966; $r = 0.59$, $p < .001$). Also confirmed was the prediction of higher susceptibility of women than of men to hypnosis. Most of the studies of variables related to susceptibility to hypnosis have been limited to one, or relatively few, measures. This study used a multivariate approach in an effort to isolate those traits, if any, which predict susceptibility. It found that the trait of gender coupled with academic major were significant in predicting susceptibility. It would appear that females who have an academic major in the College of Liberal Arts, Nursing, and Science and Math can be classified as more susceptible to hypnosis. However, one cannot say that gender and major have a combined effect. It appears that gender is the trait having the influence. The influence of major is further explained by the fact that the majors are composed of predominantly male or female students. There were no statistically significant relationships between susceptibility and grade point average.

The specific measures which contributed to the statistical differences between males and females were isolated using a univariate *F*-test. Females responded to the suggestion that their eyelids were heavy, and that they were sleepy, by closing their eyes voluntarily. They were unable to hold their left arm straight out because they felt that a force, or a weight, was pulling it down. When it was suggested that a force was pulling their hands together when their

arms were held straight out, palms facing each other, women, more than men, responded to the suggestion. They were unable to shake their heads "no" when it was suggested that it would be too difficult to do so. This also was the case when it was suggested that their eyelids were so heavy that they could not open their eyes, even if they tried.

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SEXUAL RELATIONSHIPS WITH PATIENTS AND EX-PATIENTS: THE NEED FOR MORE EXPLICIT ETHICAL GUIDELINES

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University of Sydney

There is strong consensus against sexual relationships between therapists and patients, and this is implemented in the ethical codes of professional societies. Sexual contact between therapists and former patients, however, falls within the grey area of professional ethics. Although there is little to suggest this is a more serious issue for professionals who use hypnosis than for doctors, dentists, and psychologists in general (Hawkins, 1993), it could be useful for the Australian Society of Hypnosis to provide more explicit guidelines for the benefit of its members and the protection of the public. Appelbaum and Jorgenson (1991) recommended a moratorium of at least one year from the termination of therapy to the commencement of any significant social or sexual relationship. This recommendation has stirred considerable controversy and the recent literature is reviewed. The author suggests the adoption of a two-year moratorium and further suggests the implementation of a formally documented process of consultation with a senior colleague before commencement of any significant relationship. Provision should also be made for the former patient to participate in this process of consultation. Discussion is invited.

Concern about the harmful potential of sexual contacts between therapists and clients has been recognised from ancient times. In the fourth century BC, Hippocrates stated: "Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption and further from the seduction of females or males, of freemen and slaves" (Hippocratic Oath: Edelstein, 1943). Freud (1915) was quite explicit in his warnings about the temptations and destructiveness of sexual relationships with patients, and over the last 20 years many articles in the professional literature have canvassed the issues (e.g., Dahlberg, 1971; Fahy & Fisher, 1992; Hawkins, 1993; Lazarus, 1992). The discussion has resulted in suggestions for policies that professional societies and registration boards might adopt in

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response to particular issues (e.g., Appelbaum & Jorgenson, 1991; Kagle & Giebelhausen, 1994).

THE PREVALENCE OF SEXUAL RELATIONSHIPS WITH CURRENT PATIENTS

Surveys in Europe and the U.S.A. have attempted to investigate professionals' attitudes and the actual prevalence of sexual contacts with patients (e.g., Borys & Pope, 1989; Gartrell, Herman, Olarte, Feldstein, & Localio, 1987; Kardener, Fuller, & Mensh, 1973; Lamont & Woodward, 1994; Wilbers, Veenstra, van de Wiel, & Schultz, 1992). Different definitions and interpretations of what constitutes inappropriate sexual activity, modest response rates, and reliance upon respondents to honestly report their sexual interactions with clients have resulted in reports suggesting that between 1% and 9% of various helping professions acknowledge sexual contact with clients. A very recent survey of a randomly drawn sample of 908 psychologists of the American Psychological Association, albeit with only a 43% response rate, found that 5.5% of male and 2.2% of female psychologists acknowledged having engaged in sexual intimacies with current clients (Rodolfa et al., 1994). The authors observe that these results are part of a recent trend toward lower rates of sexual acting out than were typically reported in the research conducted in the 1970s. The lower rate may possibly be explained by psychologists exercising greater self-control, increased awareness of the negative consequences for clients, the increased publicity given to malpractice suits, or perhaps a greater reluctance to report sexual interactions even anonymously. Despite the methodological limitations of these studies, it seems clear that sexual relationships between therapists and clients continue to be a problem.

There do not appear to be any published data on the attitudes and practices of Australian doctors, dentists, psychologists, or other health workers regarding sexual contact with patients. Recent reports in the media certainly suggest such cases do occur (Galletly, 1993), and they are likely to become more prominent because of the raised awareness of sexual abuse and harassment in general, the growing consumer rights movement with its more active and critical stance towards service providers, and the interests of the mass media for sensational material (Searight & Campbell, 1993).

ETHICAL CODES ON SEXUAL RELATIONSHIPS WITH CURRENT CLIENTS

Many overseas professional groups and registration boards have recently introduced or revised codes in order to explicitly prohibit sexual relationships with clients (e.g., American Psychiatric Association, 1989; American Psychological Association, 1990; National Federation of Social Workers, 1993). Locally, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) (1990, 1992) has pronounced sexual relationships with patients to

be always unacceptable and unethical. Sexual relationships are broadly defined to include any form of physical contact which is intended to produce sexual gratification. The Code of Professional Conduct of the Australian Psychological Society (1986, p. 6) states that "psychologists must avoid dual relationships that could impair their professional judgement or increase the risk of exploitation" and "personal sexual relationships between psychologists and clients are unethical" and most specifically "sexual intercourse between psychologists and clients is unethical." The weight of opinion is thus unequivocal and unambiguous: sexual relationships with current patients and clients are always unethical.

The Australian Society of Hypnosis has adopted as its ethical standard the Code of Ethics of the International Society of Hypnosis (ISH), of which it is a constituent society. Membership of ISH is restricted to medical practitioners, dentists, and psychologists, and to accommodate the multidisciplinary nature of the membership, guidelines 1(a) and 2(b) of its code of ethics refers members to the standards of ethics that apply in their appropriate professional fields. In addition, the code of ethics contains injunctions specific to hypnosis which are not likely to be covered by the codes of ethics of the respective professional fields. These pertain primarily to the use of hypnosis for public entertainment, rejection of the practice of hypnosis by lay persons, and proscription against teaching hypnotic techniques to lay persons. Thus, if the Australian Society of Hypnosis should decide to advance more explicit guidelines on sexual relationships beyond those already appearing in the codes of the constituent professional disciplines, an Australian supplement to the code of the International Society will be required.

PROFESSIONAL TRAINING ON THE ETHICS OF SEXUAL RELATIONSHIPS

The apparent continuing incidence of unethical sexual behaviour within the helping professions raises a number of issues. Many reports documenting the occurrence of unethical sexual behaviour advocate improved training in the management of sexual feelings in therapy as means of preventing infringements (Carr & Robinson, 1990; Fisher & Fahy, 1990; Rodolfa et al., 1994; Shaw, 1994; Stake & Oliver, 1991). Others urge clarification of the ethics of dual relationships and a more pronounced emphasis on education in sexual ethics (Borys & Pope, 1989; Sonne, 1994). A new scale, the Exploitation Index, is being developed to alert practitioners to their tendencies to boundary violations (Epstein, Simon, & Kay 1992).

The need for improved training is seen as especially important by some who note a reduced emphasis on psychodynamic theory and the less frequent requirement of undergoing one's own therapy in preparation for practice (Kagle & Giebelhausen, 1994). Because of the close and intimate relationships established with clients in some types of psychotherapy, practitioners need to be

alert to the dangers of developing dual relationships that could be conducive to subsequent sexual impropriety. While there is little evidence to suggest that the special phenomena of hypnosis have been used by therapists to enhance the sexual compliance of their patients (Hawkins, 1993), given perceptions about the coercive power of hypnosis by some members of the public, those who practise hypnosis need to be particularly vigilant and their professional education programs need to deal specifically with the issues. In a recent presidential address to the American Society of Clinical Hypnosis, Wall (1991, pp. 73-76) called specific attention to the ethical principle that "sexual intimacies with clients are unethical" and asserted more generally that "the acceptance of hypnosis as a legitimate tool in health care delivery requires careful adherence to appropriate ethical principles."

If training and educational programs are to be successful, they must promote understanding of the basic foundations of ethical decision making with discussion of the principles of autonomy, beneficence, non-maleficence, justice, utility, and fidelity. Exposition of these basic principles should connect them with the more specific rules and statements of our codes of ethical practice. In addition to teaching better understanding of the general principles and their applications, we need to offer clearer guidelines about unacceptable sexual behaviours. Consensus on general principles is more likely to be achieved than agreement on specific aspects of sexual ethics, but the issues need to be faced honestly (Pitty, 1992).

SANCTIONS FOR INFRINGEMENT OF ETHICAL CODES

Controversy is likely with respect to the specification of circumstances that might mitigate the severity of sanctions against professionals who transgress the proscription against sex with current patients. If sex with patients is always wrong, then it could be argued that professional societies and registration boards should act sternly, refraining from specifying mitigating circumstances because this could be interpreted as weakening the proscription. However, a more balanced view is to separate the proscription of the behaviour, which should be absolute, unequivocal and unvarying, from decisions about what sanctions are appropriate in a particular case. Sanctions may need to consider such issues as the length and depth of the therapeutic relationship, the degree of autonomy that can reasonably be attributed to the patient, the personal vicissitudes of the therapist, the extent to which the guidelines should be applied retrospectively, and whether deliberate deceit or exploitation of the patient was intended. Whether a patient was actually harmed probably ought not enter the decision because this could be considered to undermine the absolute ban on sex with patients. The termination of a therapeutic relationship in order to commence a sexual relationship is currently a controversial issue worthy of more extended discussion.

POST-TERMINATION SEXUAL INVOLVEMENT

The termination of therapy in order to clear the way for what would otherwise be an unprofessional dual relationship is in urgent need of discussion and clarification in Australia. Certainly, if a sexual relationship has developed between a therapist and a patient, there should be referral to another therapist. My advice to medical students and professionals undergoing training in hypnosis has been that, if they should find themselves involved in a romantic relationship with a patient that goes beyond what can be properly and objectively dealt with in the therapy as transference, the therapy should be terminated, the client should be referred to another therapist, and the advice of senior colleagues should be sought before continuing the relationship. Implicit in this advice is the view that romantic attachments may have some imperative and that in some circumstances they may proceed.

More careful reflection suggests that there are higher priorities that may demand complete abstinence. An explicit and complete ban on post-termination sexual relationships could reassure patients that their therapeutic relationship was less likely to be compromised by the personal motives of their therapist, enhance therapeutic objectivity in working through positive transference, and protect against premature termination of an unfinished therapy and sociopathic wooing under the guise of therapy. Such considerations are given considerable weight in some jurisdictions. Indeed, in several states of the U.S.A., sexual exploitation of a client is a felony which is not mitigated by the formal termination of the treatment, especially if termination is in order to begin the relationship (Kagle & Giebelhausen, 1994). Moreover, an absolute ban on sex with former patients has recently become an official part of the American Psychiatric Association ethics code (Gabbard, 1994). However, the new code of conduct of the American Psychological Association (1992) states that "psychologists do not engage in sexual intimacies with a former therapy patient or client for at least two years after cessation or termination of professional services" (p.1605). However, the code goes on to stipulate that the psychologist who engages in such activity more than two years after termination of treatment bears the burden of demonstrating that there has been no exploitation.

Other professional bodies are also engaged in clarifying their stance. The Council on Ethical and Judicial Affairs of the American Medical Association (1991) recently classified sexual relationships with former patients unethical if the doctor exploits the trust, knowledge, or emotions which stem from the previous professional relationship. This implies, however, that a post-termination relationship may be entertained if it is judged to be free of exploitation, but this may be the subject of considerable controversy. The ethical guidelines of the RANZCP (1990) comment that sexual relationships with former patients are generally improper, adding that a mutually acceptable termination of therapy does not necessarily mean re-establishment of equal relationships and that advice from a body of colleagues should be sought. The

code of conduct of the New South Wales Psychologists Registration Board (1990) addresses the issue of post-termination relationships by stipulating that the advice of senior colleagues should be sought before beginning any other sort of relationship. These prescriptions imply that post-termination relationships may possibly be contemplated subject to careful consideration, but there are few guidelines to assist the senior colleagues who might be consulted, nor is there specification of the length of a suitable moratorium between termination and commencement of another relationship. It seems important that more explicit guidelines be established and published, and that these should be based on clear ethical principles rather than be formulated in an ad hoc manner.

Appelbaum and Jorgenson (1991) have reviewed the areas of concern and the current approaches to regulation of post-termination sexual contact. They identify four main areas of concern about therapist–patient sexual relationships in general, and then consider how these are reduced as result of the completion and termination of therapy.

1. Patients may have significantly impaired ability to make decisions about sex with their therapist because their judgment may be clouded by distressing issues that brought them to therapy and by the development of transference often characterised by an idealisation of the therapist.
2. There may be an element of coercion in the relationship because an implicit threat exists that a patient who refuses sexual contact may be abandoned. Moreover, the privileged knowledge obtained by therapists about their patients may add to their power to exploit.
3. There may be deceit if the therapist claims that sexual contact is an appropriate part of the treatment, or offers a false reassurance that a dual relationship will not reduce the effectiveness of therapy.
4. Therapists enter into fiduciary relationships in which they assume responsibility to act in their patients' best interests rather than their own. In entering sexual relationships with patients, therapists may satisfy their own needs, but the available data suggest that many patients suffer harm as result. Baylis (1993) and Carr and Robinson (1990) offer very similar analyses and reviews.

Appelbaum and Jorgenson (1991) acknowledge that these four concerns may not be a feature of every therapist–patient sexual relationship. Indeed, some patients are able to make unimpaired decisions, free from coercion, and without subsequent ill effects. But such a benign and non-maleficent combination of circumstances is so unlikely that a complete ban on therapist–patient sex is warranted. However, though Appelbaum and Jorgenson agree with a complete ban of sex during therapy, they argue that the concerns that justify this absolute prescription are generally reduced in the post-termination context.

They conclude that the most serious harms and dangers of allowing patients and their former therapists to enter into sexual relationships can be addressed by proscribing sexual contact for a mandatory period of one year after the end of

treatment, during which all significant social contact would be precluded. After this waiting period, social and sexual relationships could be permitted because the specified moratorium would minimise problems in the chief areas of concern. This policy would balance the competing goals of protecting former patients and of avoiding excessive interference with consensual relationships. Their recommendations provoked immediate vigorous criticism but also found significant support.

Three main types of criticism are advanced by opponents to the proposal of a one-year moratorium: its promulgation would corrupt the process of therapy; it underestimates the persistence of transference with its impairment of former patients' autonomy; and it underestimates the potential severity and prevalence of harm that would ensue if it were to be adopted. The chairman of the ethics committee of the American Psychiatric Association strongly disagreed with the concept of a moratorium of set length, arguing important ethical issues such as balancing patient autonomy against potential or actual harm is not a simple function of time (Lazarus, 1992). Brown, Borys, and Brodsky (1992) responded they did not believe that it is justified clinically or ethically for a therapist to engage in sexual intimacy with a former patient regardless of the time that has elapsed between termination of treatment and the sexual intimacy. They argued that when "the possibility of sexual relationship exists in the mind of either party, but particularly that of the therapist, psychotherapy can and all too often does become a courtship, a process of grooming in which a vulnerable individual is shaped to meet the sexual and narcissistic needs of the therapist" (p. 979). A number of other respondents echoed these views and asserted that Appelbaum and Jorgenson had significantly underestimated the endurance of transference and the intensity of its grip (Burnham, 1992; Drummond, 1992; Friedman, 1992; Gabbard, 1994; Hersen, 1992; Sapir, 1992; Sonnenberg, 1992). Hersen added that sexual intimacy between therapist and patient is tantamount to a breach of the incest taboo which is not time-limited, and Sapir foresaw nightmares for committees who would have to decide whether a year had, in fact, elapsed since the end of treatment and whether any significant social contact had occurred during that year.

The proposal did find some support. Ritchie and Hays (1992) pointed out that an absolute lifetime prohibition is hard to reconcile with the primary ethical mandate of respect for patients' autonomy. They argued a one-year prohibition after termination is reasonable, justifiable, and enforceable. Aronson (1992), who declared herself a victim of sexual misconduct, argued pragmatically in favour of the policy because, while "It's never okay" is a terrific bumper sticker slogan, the principle of absolute prohibition fails to deal with the real situation and does not provide useful guidelines. The response of Schoener (1992) is particularly interesting because over two decades he and his colleagues have been consulted about many allegations and cases of therapist-patient sex. Schoener congratulated Appelbaum and Jorgenson on stimulating the vigorous debate, adding that in his experience the only consensus is agreement that

terminating a therapy in order to have sex is unethical. He observed that the vast majority of cases of post-termination exploitation involve situations where there has been no clear termination or where there was a premature termination in order to have sex. Schoener argued we need more clearly articulated standards which should include a clear definition of termination, a two-year moratorium, an absolute prohibition of sexual contact with clients of long-term transference-laden therapies, and a prohibition against sex with former clients who have suffered past victimisation.

GUIDELINES PROPOSED FOR DISCUSSION

Sexual contact between therapists and their current patients is unethical and requires no further debate, but ethical guidelines regulating sexual contact between therapists and former patients are urgently needed. These must be debated, formulated, promulgated throughout our membership, and incorporated in our educational programs. The advice to young professionals in training that "if you fall in love, simply terminate the therapy, refer the patient, and begin a relationship with the individual" is no longer adequate. Although only 60% of the psychologists canvassed by Pope, Tabachnick, and Keith-Spiegel (1987) were ready to declare that sex with former patients was always unethical, the growing weight of opinion seems to be that it should almost always be regarded as unethical. In the debate and formulation of guidelines, consideration should be given to retrospectivity because members of professions ought not be judged harshly for behaviours which were not clearly proscribed when they were enacted.

The following proposals are advanced to encourage the exchange of opinion and to assist in the formulation of appropriate guidelines:

1. We should promote empirical studies to inform the debate on the issue of sexual contact between therapists and former patients, with the objective of formulating guidelines that are more explicit than those that currently exist.
2. We should assert that sexual contact with former patients is potentially harmful to patients and therefore, with the highest goal of protecting all patients and promoting the ethical status of hypnosis, we should declare that such behaviour is almost always unethical.
3. Should we declare that sexual contact with former patients is generally unethical, we must accept that there may be situations when the proscription should be subordinate to other ethical principles, such as patient autonomy. The ambiguity of this position requires formulation of pragmatic rules to protect patients, to guide members, and to advise registration boards and other disciplinary bodies.
4. These rules should specify a set period following the termination of therapy during which there shall be no significant social contact between the therapist and former patient. Prior to the initiation of a romantic and/or

sexual relationship the therapist should consult with a senior professional colleague selected from several qualified and accessible people nominated by an appropriate officer of the Society, such as the President. The consultant, selected by the ex-therapist from those nominated, should discuss with the therapist the relevant ethical issues and document the consultation and the nature of the advice. The Society should provide opportunity for the former patient to discuss the ethical issues of commencing such a social relationship with their ex-therapist.

Perhaps, as Hamburg (1992) suggested, such rules might not have averted Hamlet's rage against his uncle for rapidly exploiting his widowed mother, but they might help therapists slow their "wicked speed, to post with such dexterity to incestuous sheets."

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THE MEANING OF TRAUMA: HYPNOSIS AND PTSD

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The onset and course of chronic post-traumatic stress disorder (PTSD) as a reaction to a traumatic event must be viewed in light of the personal meaning of the trauma to the individual. This case study details the therapeutic process involved for a 27-year-old male who had been the victim of an armed robbery and subsequently developed PTSD. A combination of hypnosis and cognitive behavioural therapy was employed to facilitate integration of the trauma and promote his ability to deal with it. Under hypnosis, the idiosyncratic nature of his reaction became apparent and he was able to abreact the affective component of the event. The case illustrates the importance of understanding the nature of the meaning of the trauma to the client and the efficacy of hypnosis in dealing with it.

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association [APA], 1994) defines post-traumatic stress disorder (PTSD) as a collection of symptoms which develop "following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity" (p. 424).

For diagnosis, the person must not only experience the event, but must respond with fear, helplessness, or horror. The symptoms include re-experiencing the event, avoidance of stimuli associated with the event, general numbing of responsiveness, and increased arousal. The symptoms must be present for more than one month, and must cause significant distress or impairment in functioning. Events which precede PTSD include personal assault, robbery, naturally or humanly caused disasters, or a life-threatening illness (APA, 1994).

Not everyone who experiences a traumatic event will experience PTSD. Scott and Stradling (1992) suggest there is considerable variation in response and that only a minority of those exposed to trauma will subsequently

experience chronic PTSD. They suggest three vulnerability factors contribute to the likelihood of the disorder developing. These are: high levels of stress or exposure; pre-existing personality or emotional disorder, such as behavioural problems, anxiety, or depression; and a family history of psychiatric disorder. Those with an adaptive coping style or an effective support network are more likely to have the resources to deal effectively with their traumatic exposure.

Many studies have found that those with PTSD do have high levels of hypnotisability (Evans, 1994; Spiegel, Hunt, & Dondershine, 1988; Stutman & Bliss, 1985), although it is not clear whether someone with high hypnotisability is therefore more likely to experience PTSD, or whether the traumatic experience heightens hypnotisability.

Hypnosis involves not only dissociation, but intense ability to focus. It is this focusing or absorption which causes the client to dissociate from her/his immediate surroundings (Burrows, 1988). Those suffering from PTSD both dissociate and focus on the traumatic event by reliving the experience.

From a clinical perspective, it is important to initiate therapy as soon as possible after the event (Evans, 1991, 1994; Spiegel, Koopman, & Classen, 1994), although the latter recognise that this is not always possible. They suggest "days after the traumatic event, anger, depression, and other symptoms are likely to intensify among many survivors, sensitising them to the continuing psychological impact of the event and perhaps increasing their receptivity to psychological help and support" (p. 19). In other words, without treatment, symptoms may be exacerbated.

The efficacy of hypnosis in the treatment of PTSD is well documented (Evans, 1991; Spiegel, 1988; Spiegel et al., 1994). Leung (1994), for example, provides a recent study in which the efficiency and effectiveness of hypnosis as a treatment strategy is described. It makes therapeutic sense to utilise a client's capacity for dissociation and absorption in dealing with their dysfunctional behaviour, cognitions, and inappropriate affect. Evans (1991) noted that hypnosis may be used to minimise and control the client's anxiety, to recover repressed or dissociated memories of the event, and to reintegrate the client's experience, although he cautions that the therapist must be aware of the high hypnotisability of many sufferers of PTSD and avoid exacerbating the problems of the client.

BACKGROUND

Alastair was a 27-year-old male, who lived at home with his parents. He had not had a serious romantic relationship, although he did have a current girlfriend. My sense of Alastair was that he was immature, in that he did not have the commitments and responsibilities of most men of his age. To me he seemed much younger than 27.

Six months prior to his consultation, Alastair had been the victim of an armed hold-up in the early hours of the morning, while he was working at a

convenience store. He was on his own in the store at the time. After the robber took money from the register, he made Alastair lie on the floor while he escaped. The attacker was armed with a handgun, was wearing a balaclava, and he had seemed "spaced out." Alastair found this particularly frightening, as he felt this meant it was impossible to predict what the perpetrator would do.

Alastair remembered the circumstances of the robbery in vivid detail, including his thoughts at the time. He did not feel any fear while being robbed; on the contrary, he remembered thinking very coolly and rationally. His description of his reaction suggested depersonalisation, as he reported feeling very cold, clear, and rational while the hold-up was in progress. Under extreme threat, he had dissociated from his emotions in order to cope with the situation.

PRESENTING PROBLEM

Alastair presented with a number of symptoms typical of PTSD. His distress at these symptoms motivated his seeking professional advice. He reported that, for about three weeks after the traumatic event, he had been unable to sleep. Now he could sleep, but had frightening dreams in which there were strong feelings of fear. These dreams had no visual component, but they were extremely upsetting.

An added concern was that he felt he was now sleeping too much. Prior to the robbery, he exercised regularly at a gym and required only seven to eight hours sleep. At this time, he was not going to the gym, but felt he needed at least 10 hours sleep per night, and then found it difficult to get out of bed.

Alastair reported what he termed "feeling flashbacks" in which he did not "see" anything, but experienced enormous fear and dread. Subsequent discussion indicated that the term "flashback" was inappropriate, as Alastair did not feel fear at the time of the robbery. In fact, he remembered feeling very cool and unemotional, as indicated above. Now, however, he was experiencing the emotions which he had not felt while being threatened and yet was not experiencing cognitive recall.

The issue which had precipitated his visit for counselling was his feeling of extremely high levels of anger which he felt were "bottled up," which was frustrating, as he did not know how to vent that anger. Although he raced cars for a hobby, this did not help alleviate the aggression he was feeling. He also felt he was re-evaluating his life and his relationships since the trauma. Two relationships he had with girlfriends had broken up because could not deal with the expectations of the two young women concerned. He felt his level of concentration was poor, and that he had no patience with people. He realised, with the latter, that he was being irrational, but he felt powerless to stop it. His symptoms had been exacerbated when a drunk came into the store three weeks after the robbery and said "This is a hold-up!" Alastair said all the feelings came rushing back to him at that point and had persisted since then.

DIAGNOSIS

Alastair's symptoms met the criteria for a diagnosis of ASD (APA, 1994) in the initial period following the hold-up. He was exposed to a life-threatening traumatic event in which he felt fear and helplessness (Criterion A) and experienced detachment, depersonalisation, and a reduction in awareness at the time (Criterion B). Subsequently, he re-experienced the emotions connected with the event (Criterion C), avoided working in the store (Criterion D), suffered increased arousal (anger) (Criterion E) and social impairment, as reflected in his breakdown in relationships (Criterion F). Onset of these symptoms was within four weeks of the trauma (Criterion G), which could not be related to any substance use or other cause (Criterion H). As the ASD symptoms of Criteria C, D, E, and F persisted for longer than four weeks, a diagnosis of PTSD was made.

The aim of therapy was to help Alastair reintegrate the experience of the trauma into his life and so alleviate the fragmentation of self which had prevented him from functioning adaptively. Regressing to the event, to allow him to work through the feelings associated with the trauma, was a means of helping him integrate his sense of self with the traumatic event he had experienced. Another goal of therapy was to combine hypnosis and cognitive behavioural therapy to help Alastair put the trauma into the past, putting a boundary around it so that he would then be able to move on.

SESSION 1

This session was spent allowing Alastair to tell his story, which he had not been able to do with anyone else. This seemed to help to reduce his arousal levels. He responded positively to my acknowledgement that he had indeed been in an exceedingly dangerous and frightening situation, an acknowledgement which is particularly important in the case of PTSD victims (Evans, 1991). I felt, as in any therapeutic relationship, that it was important to build rapport with the client.

SESSION 2

Alastair reported he was extremely stressed. He had been unable to concentrate and had been experiencing bad dreams, in which a man with a knife was moving towards him. In his dream, he ran away, but he left behind a woman and a child whom he knew, knowing they would be hurt.

We discussed the meaning of the dream for him and I suggested running away was a manifestation of what he wished he had been able to do when he was held up. The woman and the child could represent his own sense of powerlessness, while the threat from the man was an acknowledgement of the very real threat he had faced.

Alastair also recognised part of the issue for him was feeling he had no

control over what had happened to him. He had started visiting the gym again, to regain some control over his body, to “feel good” about himself.

During this session Alastair completed the Beck Depression Inventory (BDI; Beck, 1978), on which he scored 31, indicative of extremely severe depression. He scored at the 99th percentile for both state and trait anxiety on the State–Trait Anxiety Inventory (STAI; Spielberger, 1966), and had extraordinarily high state anger (94th percentile) on the State–Trait Anger Expression Inventory (STAXI; Spielberger, Jacobs, Russell, & Crane, 1983). The same test indicated that he tended to experience angry feelings often, which he was inclined to hold in (AX/EX at the 96th percentile; AX/In at the 98th percentile). This supported the self-report which he had provided at initial consultation.

His score on the Stanford Hypnotic Clinical Scale (SHCS; Morgan & Hilgard, 1978) was 3/5, indicating a moderate level of hypnotisability. We discussed hypnosis, and his misconceptions were addressed. He remained wary of the phenomenon.

Following this consultation, I reassessed the therapeutic goals in light of his high depression, anxiety, and anger scores. I felt that his depression was reactive in nature, as was the anger which he felt. Putting a boundary around the experience, placing it in the past so that Alastair could separate it from his current experience, would enable him to control the depressive symptoms. To this end, I felt that hypnosis used in conjunction with cognitive behavioural therapy (CBT) remained the most appropriate course of action. The goal of therapy was to use hypnotic techniques to facilitate Alastair’s integration of the trauma so he could again feel in control of his life. I felt that under hypnosis he would be able to regress to the traumatic event, thus allowing him to abreact and subsequently integrate the experience. CBT would aid his understanding of the emotions he was experiencing and enhance his strategies for dealing with them, at the same time helping him normalise his reactions.

SESSION 3

Alastair’s anxiety level was extremely high at this session, as he had a forthcoming exam. We arranged an application for deferral of the exam and special consideration. This seemed to alleviate much of his anxiety. He said he was feeling very alone, left out of the mainstream of life. However, he was still feeling high levels of anger, which he was unable to focus.

During this session an hypnotic induction was carried out. Alastair was quite comfortable with heights and water, but did not want any imagery of enclosed spaces. He said he wanted an open space, so that he could see everything.

Induction was achieved using progressive muscle relaxation, to help to reduce his high arousal. Deepening was achieved by taking him down a path to a large white beach, with clear, shallow water, a safe place where he could feel secure and relaxed and not be disturbed by anyone. He was allowed to experience this for a while before being asked to walk back up the path to re-alert.

As Alistair was wary of hypnosis, it was felt that a non-threatening induction and a light trance in which deeper issues were not addressed would desensitise him to hypnosis.

During the following discussion, Alastair said he liked being in that place and felt more relaxed after spending time there. His feelings regarding himself were more positive and we spent some time discussing the amount of control the client maintains while in trance.

SESSION 4

When Alastair arrived for this session, he seemed to have forgotten the positive aspects of hypnosis and was now resistant to its use. Instead, we talked of the robbery and his feelings in relation to it. He was feeling isolated from family and friends, whom he felt were trying to "fix things up" for him, without allowing him to vent his suppressed emotions. We then discussed hypnosis and some of his anxieties and misperceptions were addressed. Although Alastair was wary, he decided to try it. He stated he wanted a different induction this time. This was an opportunity to reinforce his belief in his capacity to regain control over his environment, so we discussed various techniques. He decided on the eye-roll technique (Spiegel & Spiegel, 1988). This appeared successful, as judged by his slower, more rhythmic breathing rate, which was somewhat surprising considering his earlier resistance. It may have been that when he felt a sense of control, he was able to allow himself to fully experience the phenomenon.

Deepening was achieved by asking Alastair to imagine riding down in an elevator (Kroger, 1977), with the various levels representing earlier stages in his life. Above him were floors representing his future. He was then asked, when ready, to go to the level which represented the robbery. This was somewhat distressing for him and he did not want to get out of the lift. When asked, he said he wished to leave that level. This suggestion was made and the session was terminated immediately after he took himself to his safe place on his solitary beach, to regain a sense of calmness and tranquillity. His feelings were then processed and it was reinforced to him that he would not be forced to experience anything which he was not ready to confront. It was extremely important for him to have complete trust in that and in me.

SESSION 5

Alastair seemed more comfortable when he arrived for this session. He asked to lie on the floor rather than sit in a chair for hypnosis and also asked for a different induction. I asked him to focus on a spot on the wall and suggested his eyelids would become heavy, until he felt it was more comfortable to close them. Deepening was achieved by suggesting a bucket hanging on his wrist, gradually filling with sand. As it became heavier, his arm would gradually lower to the floor. This occurred without hesitation.

Alastair was then taught anchoring, by tapping one finger on the other hand. I suggested that, when he did this, he would return to his special place where he was safe, tranquil, and relaxed. The agreed purpose of the session was to again attempt to have Alastair regress to the hold-up. He was closely monitored, particularly with respect to his breathing, to ensure that his distress did not become too great.

The elevator technique was again used to take him back to the trauma. This method was used so that Alastair could control when he opened the doors and whether he stepped out of the elevator to become part of the scene. He was also able to step back into the elevator at any time, shut the doors, and leave that level.

Alastair was able to reach the point where he could open the doors of the elevator and could see the arm and the balaclava of the robber, although this was a slow process in which a deal of anchoring was required. It was effective in reducing his anxiety to a level where he was willing to resume his attempt to return to the hold-up. Trance was terminated when I felt enough progress had been made in the session for the moment.

During our discussion after re-alerting, Alastair was positive about the experience, expressing surprise at the amount of control he felt he had in trance. He was extremely keen to continue our sessions and felt accessing his feelings during the hold-up was essential to his "survival." He expressed the belief that his PTSD was stopping him from living. His view was strikingly evocative of the view of Spiegel et al. (1988) regarding trauma and dissociation and the subsequent diminution of quality of life.

SESSION 6

Alastair had some success in his car racing. He reported he was enjoying the social side of his sport and this was unusual for him since the hold-up. He expressed positive feelings, including a feeling of inner strength. This related to his sense of taking back control over his life. After discussion, Alastair decided he would like a progressive muscle relaxation induction. Deepening again involved walking down a path to his special place. Anchoring was reinforced.

In this session, regression was achieved by having the client imagine climbing down a ladder to a window, on the other side of which was the robbery. Again, Alastair had control, as he determined when he opened the window. I made the suggestion it was a very strong window through which bullets could not penetrate and no-one could see through it from either direction. He had the choice of either opening it and looking through, or climbing through it to the other side.

There was much reluctance on Alastair's part to approaching the window. I continued to make anchoring suggestions and he occasionally did this spontaneously. Finally, he entered the room. A breakthrough came when he was asked to examine what it was inside him which was causing this enormous fear

and he said that he was afraid of being raped.

When we discussed this after reorienting from the trance, Alastair said he had not realised the fear of being raped was there, but that he was now aware that it was. This was a striking example of the idiosyncratic nature of reactions to a traumatic event. As Scott and Stradling (1992) suggested, it is the personal meaning of the event which determines the reaction of the individual.

SESSION 7

Alastair said he knew what the terrible fear inside him was, but he felt that it was unfinished. He reported his concentration was improving, but his memory was still poor. My sense was that he wanted miracles from hypnosis. He needed to be made aware the best he could expect was a return to his pre-trauma levels of functioning. Alastair was also beginning to see some positive aspects to the hold-up, feeling that it precipitated an examination of aspects of himself and his life.

A trance was again induced and Alastair was regressed to the hold-up. He experienced far less anxiety this time. My therapeutic goal at this stage was to have the robber leave the store after stealing the money, symbolically walking out of Alastair's life. When this suggestion was made, Alastair became distressed and said the robber was stuck in the door and could not get out. When asked to describe what was happening, he reported the robber had taken out his penis, and that it was erect. His breathing became rapid again, so the suggestion was made that he was in his special place, feeling calm and relaxed. Alastair was then brought out of trance. During debriefing when I questioned him about the actual behaviour of the robber, he confirmed that there were no sexual overtones.

I had a sense of relief the session had to be ended then, as I felt concerned I was getting into areas beyond my expertise. One aspect which concerned me was whether Alastair was fantasising and receiving some sexual gratification from telling me explicit sexual details.

My meeting with an experienced counsellor clarified these issues for me and I decided I would go with Alastair's direction, but that the next session should not be hypnosis, but an evaluation of where we were going with therapy in general, and hypnosis in particular. This became a valuable session, in that many issues were examined and some aspects clarified for Alastair. He reported that, during the last session, he had felt a mixture of anticipation and fear. There was some sexual excitement and a sense of wanting to "get it over with." He found it extremely difficult to describe his emotions when asked to do so. He was not aware of having felt sexually threatened before, although he felt that he had not really confronted his sexuality. There was clearly some ambivalence there.

Alastair said he had a rich fantasy life, with occasional homosexual fantasies. He felt a fear of being raped had affected his sexual life and this may have been the cause of his not trusting his ex-girlfriend. I felt it may be necessary for him

to take his fantasy to completion under hypnosis, in order to psychologically complete his experience. Use of an affect bridge to access possible earlier sexually threatening situations would also be beneficial.

SESSION 8

Alastair was keen to analyse what was happening. He presented as more assertive and began our session by saying he was "feeling very heterosexual." He also said he felt his memory and concentration were improving.

When we began the induction he seemed very nervous, with a deal of nervous laughter, and gave me many instructions as to what techniques he wanted me to use. After induction and deepening, the rape scene was suggested. The affect bridge elicited nothing. He did not recall feeling like this before.

I suggested he take the rape through to its conclusion. Alastair said the image froze when the robber was about to rape him. He spontaneously reversed the roles and found that the same thing happened. He did not feel he wanted to rape the robber. Alastair then went to his safe, special place, prior to being reoriented.

During discussion following this hypnotic session, Alastair said he felt the issue regarding his sexuality had now been resolved. He felt no doubt as to his heterosexuality, because when given the opportunity, his unconscious had chosen not to travel down the path of homosexuality. We discussed the differences between fantasy and reality and the ability to experiment in our fantasy life with behaviours which would be too threatening in reality.

It was decided to conclude therapy. Neither he nor I felt further sessions were necessary in the immediate future, although I stressed to him he should contact me if any unforeseen issues arose.

Alastair was reassessed on the BDI, on which his score had reduced in the three months of therapy from 31 to 4. He had gone from the 99th percentile on the STAI state and trait anxiety to the 58th percentile (state) and 64th percentile (trait). His anger levels had reduced to less than the mean.

FOLLOW-UP

Alastair was contacted a month after his final session. He reported life was going well for him and that he was managing his studies again. As a postscript, four months after our final session I received a letter from Alastair saying that, much to his surprise, he had passed all of his exams and was now enrolling in his final year.

SUMMARY

Alastair was suffering from PTSD after being the victim of an armed robbery. The robbery had stirred unconscious images of arousal and excitement with which he could not deal. His PTSD symptoms were exacerbated by these

unresolved and unconscious issues related to his sexuality. His prone position on the floor and total vulnerability had resulted in a fear of rape which was also tinged with excitement. Although there had been no sexual overtones in the robbery, sexual feelings had been aroused, an example of the importance of the personal meaning of an event in determining PTSD reactions (Scott & Stradling, 1992). Hypnosis allowed his unconscious to take the fantasy as far as he wanted. Alastair felt that his wish not to take the rape to its conclusion, indeed his inability to do so, helped him satisfactorily resolve his sexual guilt feelings.

The efficacy of hypnosis was apparent, in that it allowed him to make the decision free from the conscious constraints under which he had previously been operating.

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PREDICTION OF HARVARD AND STANFORD SCALE SCORES WITH A PHENOMENOLOGICAL INSTRUMENT

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The present study investigated the extent to which the Phenomenology of Consciousness Inventory (PCI; Pekala, 1982, 1991a) predicted Stanford Hypnotic Susceptibility Scale: Form C (Weitzenhoffer & Hilgard, 1962a) scores and replicated previous results (Forbes & Pekala, 1993; Pekala & Kumar, 1984, 1987) with the Harvard Group Scale of Hypnotic Susceptibility (Shor & Orne, 1962). Psychology students ($N = 160$) experienced the Harvard Group Scale and subsequently completed the PCI in reference to a four-minute sitting quietly period embedded in the Harvard. Fifty-three of these subjects were subsequently seen for an individual hypnotic assessment employing the Stanford Hypnotic Susceptibility Scale: Form C. Subjects completed the PCI in reference to a four-minute sitting quietly period embedded in the Stanford. The results showed that the PCI predicted actual Stanford Scale scores more effectively than the Harvard, even though these predicted scores were based on a regression equation developed from the Harvard Scale. The results add support to the validity of using the PCI as a measure of hypnotic susceptibility that appears to correlate reasonably well with both the Harvard and the Stanford Scale scores.

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PREDICTING HYPNOTIC SUSCEPTIBILITY VIA A PHENOMENOLOGICAL APPROACH

Previous research by Pekala and Kumar (1984) has suggested the possible usefulness of a self-report instrument called the Phenomenology of Consciousness Inventory (PCI; Pekala, 1982, 1991b) in the prediction of hypnotic susceptibility as measured by the Harvard Group Scale of Hypnotic Susceptibility (Shor & Orne, 1962). The PCI is a self-report inventory completed retrospectively in reference to an immediately preceding stimulus condition. It consists of 12 major and 14 minor dimensions of consciousness that assess specific aspects of phenomenological experience such as imagery, rationality, memory, self-awareness, and so forth.

Pekala and Kumar (1984) found a multiple correlation coefficient of 0.71 when PCI (sub)dimensions were used to predict the Harvard scale scores. The regression equation from this study was then used to predict the Harvard scale score of 434 subjects in a subsequent cross-validation study (Pekala & Kumar, 1987). The validity coefficient (correlation of the predicted Harvard Group Scale scores with the actual Harvard scores from the 1987 study) was found to be 0.65. An additional cross-validation by Forbes and Pekala (1993) generated a validity coefficient of 0.61 using the same regression equation from the 1987 study.

The PCI-based predicted Harvard Group Scale (pHGS) scores range between -.71 and 11.77 (usually between 1 and 9) as opposed to the Harvard scores which range between 0 and 12. Pekala and Nagler (1989) noted that high pHGS scores are reflective of phenomenological experiences of the high susceptible subjects (as measured by the Harvard scale). They also noted that subjects scoring 10 or above on the Harvard scale averaged a pHGS score of about 7. In as much as the pHGS scores reflect the subjective experiences on such PCI (sub)dimensions as rationality, volitional control, absorption, self-awareness, alterations in body image, meaning, and perception associated with the Harvard scale induction, they might be used to assess if a hypnotic-like state has been achieved in reference to a particular stimulus condition.

Pekala (1995a) found a correlation of .51 between the unstandardised regression equation coefficients of the PCI (Pekala & Kumar, 1987) completed in reference to a short hypnotic assessment procedure and the actual scores of the Harvard, completed a week later. The study also found that an increase in the pHGS score was associated with increased, vivid imagery and increased eye catalepsy. The research suggested that the PCI pHGS score, given in reference to a short hypnotic assessment procedure, was able to predict hypnotic susceptibility a week later, as measured by a different assessment procedure, the Harvard Group Scale.

The Harvard Scale score is generally assumed to measure the "trait" of hypnosis (Hilgard, 1965; Kumar, Pekala, & Cummings, 1993), a person's proclivity to experience various hypnotic behaviours and experiences. However,

administration of the Harvard, or similar hypnotic assessment inventories like the Stanford, Forms A and B (Weitzenhoffer & Hilgard, 1959), or C (Weitzenhoffer & Hilgard, 1962a), gives the experimenter an estimate of the level of hypnotic suggestibility that is associated with a particular hypnotic induction procedure of the Harvard or the Stanford.

Typically, however, during an actual clinical hypnotic intervention, it is not possible to assess hypnotic susceptibility, unless the Harvard or Stanford induction procedures are administered within that intervention. Clinicians and experimentalists alike, however, tend not to administer standardised instruments because of the intrusiveness of such interventions.

The PCI-based predicted Harvard Group Scale score, on the other hand, gives an estimate of the suggestibility level of a particular client for a particular hypnotic induction, because of its correlation with hypnotic susceptibility (Forbes & Pekala, 1993; Pekala & Kumar, 1984, 1987). In conclusion, in situations where hypnotisability cannot be assessed with traditional instruments, the PCI pHGS score may provide a substitute measure to determine an estimate of the client's hypnotic susceptibility. As such, the PCI may be helpful as a non-intrusive measure of hypnotic susceptibility, where some of the more blatant demand characteristics associated with passing (or not passing) various behavioural items of standard hypnotisability scales can be avoided.

RATIONALE FOR THE PRESENT STUDY

To date, the PCI pHGS scores have only been assessed in reference to one standardised hypnotic assessment scale, the Harvard Group Scale. Given that Harvard Scale was primarily intended to be used as an initial group screening instrument, prior to the administration of an individually administered scale like the Stanford Hypnotic Susceptibility Scale (SHSS), Form C (Weitzenhoffer & Hilgard, 1962a), it was decided to examine the usefulness of the PCI in assessing pHGS scores in reference to the SHSS, Form C (SHSS:C). The Stanford Scale, Form C, was developed from prior Forms A and B of the Stanford Scales (Weitzenhoffer & Hilgard, 1959), and written so as to increase the variety of hypnotic experiences assessed. The Form C assesses hypnotic experiences dealing with age regression, dreaming, and positive and negative hallucinations in the sensory areas of vision, audition, taste, and smell, in addition to containing the more standard items like hand lowering, arm rigidity, and arm immobilisation. Due to the more difficult nature of the items, it may be considered as having a somewhat "higher ceiling" than the previous Forms A and B, and the Harvard scale.

The main purpose of the present study was to see how well PCI-based predicted Harvard Group Scale (pHGS) scores correlate with actual Stanford scores. If there is high predictability of actual Stanford scores, then it will help to further validate the use of PCI as a non-intrusive measure which can be used in clinical or therapeutic interventions where the standard scales cannot be administered beforehand.

DESIGN OF THE PRESENT STUDY

In the present study, the Harvard scale was first administered by the second author, across groups of subjects, and then in a separate session the SHSS:C was administered individually by the first author without knowledge of the subjects' scores obtained on the Harvard. The PCI, Form 1, was administered in reference to a sitting quietly period embedded in the Harvard induction, and the PCI, Form 2, was administered similarly in reference to a sitting quietly period in the Stanford induction.

The above manipulations allow the computation of two actual scores, the actual Harvard and Stanford Scale scores, and two predicted scores based on PCI variables—the predicted Harvard Group Scale (pHGS) scores and predicted Stanford (Stanford pHGS) scores. Note that the notation “pHGS” for the Stanford implies that this score is based on PCI (sub)dimension regression weights developed from the Harvard scale. Thus the Stanford pHGS scores are computed utilising the PCI scores obtained for the Stanford administration, but using the regression weights developed from the administration of the Harvard Group Scale in a previous study (Pekala & Kumar, 1987).

Since the correlations between the Harvard and Stanford scales tends to be moderately high (.60 to .70) (Register & Kihlstrom, 1986), it was predicted that the Harvard and Stanford scores would be significantly and highly correlated. Given the results of previous studies (Forbes & Pekala, 1993; Pekala & Kumar, 1984, 1987) it is expected that the validity coefficient for the Harvard pHGS (utilising the regression equation of the 1987 study) in predicting the actual Harvard scores would be similar to those obtained in previous studies. Assuming that the phenomenological experiences are similar during the Harvard and Stanford inductions, it is expected that the Harvard pHGS scores will be significantly and positively correlated with the actual Stanford scores and the Stanford pHGS scores. Furthermore, a regression equation computed to predict the actual Stanford scores from the PCI scores (administered in reference to the Stanford) will yield a multiple *R* similar in magnitude to that obtained in the prior study with the Harvard scale (Pekala & Kumar, 1987), with similar variables in the regression equation.

METHOD

Subjects

Subjects were 160 introductory psychology students who participated in the study to fulfil a departmental research requirement. Participation was voluntary inasmuch as subjects could partake in any ongoing projects and terminate their participation at any time with impunity.

Materials

The Harvard Group Scale of Hypnotic Susceptibility: Form A (Shor & Orne,

1962) was used to measure hypnotisability during an initial hypnotisability screening using groups of subjects. The Stanford Hypnotic Susceptibility Scale: Form C (SHSS:C) (Weitzenhoffer & Hilgard, 1962a) was used to measure hypnotisability on an individually administered protocol.

The Phenomenology of Consciousness Inventory (PCI; Pekala, 1982, 1991a) was used to map phenomenological experience. The PCI is a 53-item self-report inventory that is completed retrospectively in reference to a preceding stimulus condition. The dimensions (and associated [sub]dimensions) of the PCI include: positive affect (joy, sexual excitement, love), negative affect (anger, fear, sadness), altered experience (body image, time sense, perception, unusual meanings), attention (direction, absorption), imagery (amount, vividness), internal dialogue, self-awareness, state of awareness, memory, rationality, volitional control, and arousal. For this study, a 5-point Likert scale was used separating the dipoles of each PCI item. Subjects rated each item according to this 5-point scale. There are two forms of the PCI. Both have exactly the same items, but each form has a different sequence of items arranged in a randomised block design.

The PCI has been shown to have adequate construct, discriminant (Kumar & Pekala, 1988, 1989; Pekala, 1991a; Pekala & Forbes, 1988; Pekala, Forbes, & Contrisciani, 1989; Pekala & Kumar, 1986, 1989; Pekala, Steinberg, & Kumar, 1986) and predictive validity (Forbes & Pekala, 1993; Pekala, 1991a; Pekala & Kumar, 1984, 1987).

Procedure

Subjects experienced the induction procedure of the Harvard Group Scale of Hypnotic Susceptibility (Shor & Orne, 1962), which was shortened approximately 10 min to accommodate to the time constraints of the study. This was done by eliminating redundant phraseology prior to the various behavioural suggestions of the procedure. (Prior research indicated no contraindications to doing this, Kumar & Pekala, 1988, 1989; Pekala & Kumar, 1984.) After the eye catalepsy instructions but before the post-hypnotic suggestion and amnesia, subjects experienced a four-minute time period during which they were told: "to continue to experience the state you are in right now. For the next several minutes I'm going to stop talking and I want you to continue to experience the state you are in right now."

After repeating these instructions, the experimenter (the second author) was silent for four minutes. The remainder of the Harvard Group Scale instructions were then given. After de-induction and after writing down a list of the hypnotic suggestions remembered (and after removal of the amnesia), the participants were specifically told to complete the PCI, Form 1, in reference to the four-minute time period when the experimenter stopped talking. Subjects then completed the response items of the Harvard Scale test booklet.

Sixty subjects (out of the 160) were randomly selected from each of the low (scores of 0 and 2), medium (3 and 8), and high (9 and 12) susceptible

categories, based on their Harvard Scale scores. These subjects were recontacted and asked to participate in the second hypnotic assessment conducted on a one-to-one basis. The first author, who was blind to the subjects' scores on the Harvard, administered the SHSS:C. After the negative visual hallucination, but before the instructions to the post-hypnotic amnesia, the experimenter told the subject:

For the next several minutes I'm going to stop talking and I want you to continue to experience whatever you are experiencing right now. After several minutes I will start talking again. OK. For the next several minutes continue to experience whatever you are experiencing right now. I will just sit here with you during this time.

After a four-minute pause the experimenter continued with the administration of the SHSS:C. After de-induction, the subject completed the PCI, Form 2, in reference to the four-minute sitting quietly period embedded in the Stanford.

RESULTS

Analyses Using Prior Regression Equation

The pHGS scores were generated from the PCI (sub)dimension scores obtained during the Harvard and Stanford administrations. These predicted scores will be referred to as Harvard pHGS and Stanford pHGS scores, respectively. The PCI-based regression equation computed in the Pekala and Kumar's (1987) study was used for this purpose. The prediction equation, with PCI (sub)dimensions in parentheses (* = multiplication), is as follows: pHGS score = .31*(altered state of awareness) - .27*(self-awareness) + .13*(altered time sense) + .19*(absorption) - .28*(volitional control) + .23*(rationality) - .11*(internal dialogue) + .35*(altered experience) - .14*(memory) - .07*(altered body image) + 4.15 (the constant).

Table 1 illustrates the means, standard deviations, and the correlation coefficients among the actual Harvard and Stanford Scale scores and predicted Harvard pHGS and Stanford pHGS scores. The actual Harvard and Stanford scores were significantly correlated ($r = .73$; $p < .001$); the two pHGS scores were also significantly correlated ($r = .41$; $p < .01$). The two susceptibility scales were significantly ($p < .01$) correlated with the two predicted Harvard scores (see Table 1). The Stanford pHGS correlated significantly [$t(50) = 3.59$, $p < .01$] higher with the actual Stanford scores ($r = .86$, $p < .001$), than with the actual Harvard scores ($r = .69$, $p < .001$); the actual Harvard scores-Stanford pHGS scores correlation (.69) was, however, not significantly [$t(50) = 1.89$, $p > .05$] different from the actual-Harvard scores-Harvard pHGS score correlations ($r = 0.49$, $p < .01$).

Table 1 Means, Standard Deviations, and Intercorrelations of Variables ($N = 53$)

Variable	Mean	SD	Harvard score	Stanford score	Harvard pHGS score	Stanford pHGS score
1 Harvard score	5.98	3.99	1.00			
2 Stanford score	5.32	4.18	.73*	1.00		
3 Harvard pHGS score	4.96	1.25	.49*	.40**	1.00	
4 Stanford pHGS score	5.08	1.39	.69*	.86*	.41**	1.00

* = $p < .001$. ** = $p < .01$.

Step-Wise Regression Using the Present Study's Data

A multiple regression was then computed to predict the subjects' actual Stanford Scale scores from the PCI (completed during the sitting quietly period embedded in the Stanford). Alpha to enter and remove was set at .20. Table 2 illustrates the four PCI variables (volitional control, altered state of awareness, altered experience, and self-awareness) that made it into the final equation. The regression equation generated a multiple R of .87, accounting for 75% of the variance. All four PCI variables had Pearson r s of above .70 with the actual Stanford Scale scores.

DISCUSSION

Correlational Analyses

Except for the study by Pekala (1995a), all of the research to date concerning hypnotisability and the PCI has been done with the Harvard Group Scale of Hypnotic Susceptibility (Shor & Orne, 1962). This is the first study that looked at another standardised hypnotic assessment instrument, the SHSS:C

Table 2 Multiple Regression Predicting Actual Stanford Scores from PCI Dimension Scores During the Stanford Scale Administration

PCI variable	R	R^2	r	r^a
Volitional control	.79	.61	-.79	-.52
Altered state of awareness	.85	.72	.77	.55
Altered experience	.86	.74	.74	.50
Self-awareness	.87	.75	-.71	-.49

^aPearson r s from study by Pekala and Kumar (1987).

(Weitzenhoffer & Hilgard, 1962a), and the PCI. As expected, the correlation of .73 between the Harvard and the Stanford, Form C is consistent with that usually found in the literature (Brown & Fromm, 1986; Register & Kihlstrom, 1986). It suggests that these scales were validly administered even though two different experimenters were used, and the experimenter administering the Stanford Scale was unaware of the subjects' Harvard scores.

It was predicted that the validity coefficient for the Harvard pHGS scores in predicting actual Harvard scores would be about .60. In the present study, however, this correlation ($r = .49, p < .001$), although significant, was less than that found in three other studies (Forbes & Pekala, 1993; Pekala & Kumar, 1984, 1987). This difference may be due to chance or it may be related to the smaller sample size of the present study relative to the other studies, such that variability may have been restricted.

As expected, the Harvard pHGS scores were significantly and positively correlated with the actual Stanford ($r = .40, p < .01$) and Stanford pHGS scores ($r = .41, p < .01$). Furthermore, the actual Harvard scores–Stanford pHGS scores correlation ($r = .69$) was not significantly ($p > .05$) different from the actual Harvard scores–Harvard pHGS scores correlation ($r = .49$). These results provide support to the assumption that the phenomenological experiences during the Harvard and Stanford are similar. The results also lend credibility to the use of pHGS scores as a valid measure of hypnotic susceptibility in situations where the standard scales may be too intrusive.

The actual Stanford scores–Stanford pHGS scores correlation (.86) is impressive. It was significantly ($p < .01$) higher than the actual Harvard scores–Stanford pHGS correlation (.69) and also much higher than the actual Harvard scores–Harvard pHGS scores ($r = .49$). This is intriguing, since the pHGS scores are based on regression equations derived with the Harvard (Pekala & Kumar, 1987).

The high correlation with the Stanford may partially relate to the distribution of the sample. The authors felt it important to obtain a sample of individuals at the low and high ends of hypnotisability. Hence, the potential sample of subjects, when recruited for the Stanford, consisted of 20 individuals who scored between 0 and 2, and 20 individuals who scored 9 to 12 on the Harvard. This left 20 individuals who scored between 3 and 8 on the Harvard, where approximately 70% of the distribution would be expected to be (Weitzenhoffer & Hilgard, 1962b). Although 16 subjects were recruited with Harvard scores ranging between 3 and 8, only 11 individuals were subsequently found to have Stanford scores within this range. Hence, the actual Stanford Scale scores are maximised in the low and upper distributions of the scale. Given this bimodal distribution and the lack of more medium susceptible subjects, the correlation coefficient is probably inflated.

Regression Analyses

The regression equation (Table 2) using the PCI dimensions to predict actual

Stanford Scale scores may also shed some light on the high correlation between the actual Stanford Scale score and the Stanford pHGS score. The four variables found in this equation were the same four variables with the highest beta weights in the regression equation from prior research (Pekala & Kumar, 1987) computed to obtain the pHGS scores. Thus, the high correlation between the actual Stanford Scale scores and the pHGS scores during the Stanford administration may not be that surprising. In any case, these results further support the assumption that the phenomenological experiences obtained during Harvard and Stanford administration are similar, giving us greater confidence in the use of PCI in situations where there is no standard measure of hypnotisability available.

Future Research

The findings of the present study support the possible usefulness of the PCI in predicting hypnotic susceptibility (see Pekala, 1995a, 1995b). However, because of the small sample size, the present study did not look into the computation of pHGS scores based on a regression equation using the PCI scores given in reference to the individualised Stanford scale administration. It is possible, given the rather high multiple R (.89) obtained in the present study (in predicting the Stanford scores from the PCI), that a regression equation based on Stanford would be more useful than the Harvard pHGS score. This might be true not only in predicting the Stanford, but also the Harvard Scale scores, due to the Stanford's higher ceiling and utilisation of more phenomenological items than the Harvard. Hence, replication of the present study that uses a larger sample size with a more normal distribution is recommended.

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