Therapist's Manual:
Interpretation of the Phenomenology of Consciousness Inventory: Hypnotic Assessment Procedure (PCI-HAP)

by

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Overview

Welcome to the PCI-HAP interpretative manual!

In the paragraphs to follow I have put together for the interested clinician and researcher information on how to interpret the various scores obtained from the PCI-HAP. This interpretative manual needs to be used in conjunction with the PCI-HAP administrative manual (Pekala, Kumar, & Maurer, 2009) which describes how to administer and score the PCI-HAP and the use of the EXCEL scoring protocol. The paragraphs to follow assume that the clinician has read the PCI-HAP administrative manual and is familiar with the PCI-HAP and its pre- and post-assessment forms. Because the PCI-HAP is a fairly sophisticated instrument, the reader of this manual should also have taken a workshop on the PCI-HAP so that he or she can be familiar with the various concepts, and the theory and research behind those concepts, as discussed below. Information on the PCI-HAP including the administration manual, the PCI, and the EXCEL scoring program can be obtained at: www.quantifyingconsciousness.com.

Before the PCI-HAP Review

Immediately after the client completes the PCI-HAP in my office (or if completed as a group at the VA hospital where I work at my "day" job), I will briefly review with the client their responses to the debriefing form. If this is an individual session, I will have used the therapist debriefing form, and will go over with the client their individual responses immediately after the hypnotic induction, including getting clarification on any negative effects that they may have reported. If the PCI-HAP is given in a group, as the individuals complete their forms and hand them in, I briefly review with them, on an individual basis, their responses to the PCI-HAP self-report debriefing form, (and also make sure that they completed all 53 items on the PCI), asking for clarification concerning any negative effects they may have endorsed.

The PCI-HAP is then scored with an EXCEL program (see Pekala, Kumar, and Maurer, 2009, on how to do that) in the interim and the client's results are reviewed with them at their next scheduled session. Appendix A (pages 27-31) lists the 5 page printout that you obtain when the data from the PCI-HAP is typed in. (It might be good at this point to print out the 5 page printout and have it at your side as you review the pages to follow.) Many times for my private clients, I will give them the PCI-HAP EXCEL print-out. When I give the PCI-HAP in a group at the VA hospital where I work, I do not usually give the client a copy of the print-out.

The PCI-HAP Review

Immediately before discussing with the client the EXCEL printout, I will typically again review the client's responses to both the pre-assessment and the post-assessment forms with them. This allows me to refresh the memory of the client, since it will typically be a week or more until I have a chance to meet with the client and review with him or her their PCI-HAP results. Whereas the pre-assessment usually does not present much data with which to dialogue, the post-assessment debriefing form will allow you to get an idea as to how the client perceived the hypnotic assessment.

The client's perceptions and subsequent attributions concerning those assessments are extremely important, I believe, as these beliefs and attributions will determine not only how the client feels about how hypnotized he or she became, but also how these perceptions can be shaped by the therapist to allow the client to become ego involved in the hypnotic process.

Despite the education given to the client about hypnotism and the hypnotic assessment that I typically do, clients after the assessment may still have misconceptions about hypnotism. It is not unusual for clients to say that they heard other noises in or outside the room, and consequently, that they were not hypnotized (believing, erroneously, that they must become a "zombie" during hypnotism to be deeply hypnotized). Completion and review of the PCI-HAP allows the clinician to ferret out those misconceptions and begin to allow the client to better understand his or her hypnotic talents, and with the therapist's help, begin to utilize those talents for therapeutic gain. And by quantifying the responses obtained from the pre- and post-assessment forms, the therapist also has normative data as to the client's hypnotic talents.

Once reviewing the pre- and post-assessments, I then proceed to the EXCEL print-out. In the pages to follow, I describe the different aspects to the printout along with comments and interpretations concerning such. In terms of what I address first, second, third, etc., it is important to determine if the reliability index (RI) score is valid (less than 2.3 - the right side of page 2 of the print-out, page 28), and if the client's validity index (the Wakefulness Total Score, WTS - bottom right of page 4, page 30) is appropriate.

Obviously, PCI-HAPs that are unreliable or invalid are problematic and the client may need to be retested. However, even unreliable PCI-HAPs may still furnish useful information about the hypnotic experience (from the pre- and post-assessments) that can be subsequently incorporated into any hypnotic protocol implemented for the client.

The Major PCI-HAP Domains

Once the clinician determines that the PCI-HAP has been completed reliably and validly, I usually, although not always, will go to the top of the summary page (page 4 of the EXCEL print-out, page 30) to determine how the client scored on the four domain scores found there, including the summary score, the Hypnotic Responsivity Index (HRI). I explain to the client that "hypnotism" typically subsumes several different aspects or "domains," and the client does not need to score high on all four domains for hypnotism to be useful. Obviously high scores on several of the domains mean the client may be quite hypnotically responsive, especially if imagoic suggestibility and the hypnoidal state scores are high.

As Wagstaff (1981), Baker (1990), Kihlstrom (2003), Woody and colleagues (Woody, Barnier, & McConkey, 2005; Woody, McConkey, 2003) and many others (Barabasz & Watkins, 2005; Lynn & Rhue, 1988; Lynn & Sherman, 2000; Killeen & Nash, 2003; Sheehan & McConkey, 1982) have theorized, "hypnotism" appears to subsume a number of different domains (Brown & Fromm, 1986); the activation of a particular domain(s) leading to the perception of being "hypnotized."

The four major domains mapped by the PCI-HAP include trance state, suggestibility, expectancy, and self-perceived hypnotic depth. I tell the client that these are not all the domains associated with being "hypnotized," but that they are four important ones, and ones that we will draw upon in helping them use hypnotism and self-hypnosis. Whereas the adjusted hypnoidal state score gives a measure of "trance depth," the imagoic suggestibility score gives a measure of suggestibility. The average total expectancy score gives a measure of the client's expectancy concerning his hypnotic responsivity, averaged across the pre- and post-assessment forms. And the self-reported hypnotic depth score gives the clinician and researcher a measure of how deeply hypnotized the client or research subject felt himself to be.

***The Hypnoidal State Score*.** The domains listed at the top of page 4 of the EXCEL program (page 30) incorporates several important areas for understanding the nature of being hypnotized. The hypnoidal state score gives a measure of trance depth or what Weitzenhoffer

(2002) would call "hypnosis:" "I will otherwise generally reserve the term *hypnosis* for the 'state' and the term *hypnotism*, for the production, study and use of suggestion with the state of hypnosis presumably being present, whether or not it adds anything tangible to the situation" (p. 210). Being normed against the Harvard, the hypnoidal state score allows the researcher and the clinician to get an objective measure of "trance depth" that correlates about .60 with scores on the Harvard (Forbes & Pekala, 1993; Pekala & Kumar, 1984, 1987). Research has also supported the convergent and discriminant validity of this score (Pekala et al., 2006; Pekala et al., 2009b,c).

***The Imagoic Suggestibility Score*.** The imagoic suggestibility score gives a measure of the imagery vividness of the client's hypnotic dream. This score in recent research (Pekala, Kumar, Maurer, Elliott-Carter, Moon, & Mullen, 2009c) was found to account for almost half of the relative variance associated with the perception of being hypnotized. (See Table 1 - page 33. So as not to disrupt the flow of this document, all tables and figures have been put at the end of this manual.)

The Average Total Expectancy Score. The average total expectancy score is the average of the two pre-hypnotic expectancy scores: the pre-hypnotic estimated hypnotic depth score and the pre-hypnotic therapeutic expectancy score plus the post-hypnotic therapeutic expectancy score divided by two. It represents the average expectancy score across pre- and post-hypnotic conditions. Research (Pekala et al., 2009c) found that it accounted for the second largest percentage of the relative variance in being hypnotized, as assessed by the self-reported hypnotic depth score, the fourth variable listed at the top of page 4 (page 30) of the EXCEL scoring protocol.

***The Self-Reported Hypnotic Depth (srHD) score*.** The srHD score gives you a measure of how deeply hypnotized the client felt themselves to be. I believe this is a very important clinical measure. If the client believes that they were not hypnotized, what are the odds that they will practice self-hypnosis, or be open to hypnotic interventions? Knowing how deeply the client or research subject felt themselves to be will give you some insight into their own attribution concerning their hypnotic responsivity.

***How These Scores Relate To One Another*.** Table 1 (page 33) shows a regression analysis of a paper submitted for publication consideration (Pekala et al. , 2009c). In this research paper we attempted to predict self-reported hypnotic depth from the other variables of the PCI-HAP. As the reader can see, almost two-thirds of the variance (R^2 = .645) of a person's perceived hypnotic depth (the srHD score), was accounted for by 4 variables: imagoic suggestibility, total combined expectancy, the eye catalepsy item, and hypnoidal state. Of importance to the reader is the "standardized coefficient" column.

Standardized coefficients indicate “with a good deal of confidence, whether specific predictors make contributions to the criterion that are unrelated to the contributions made by the other variables” (Grimm & Yarnold, 1995, p. 41), hence allowing for a comparison of “the relative contributions of each predictor to the overall effect” (p. 41). (Because standard coefficients can add up to less than, or over, 100%, the standard coefficients need to be examined in reference to each other, and the coefficient does not necessarily indicate the exact percentage of variance accounted for.)

Imagoic suggestibility accounted for nearly half of the relative variance, suggesting that imagoic suggestibility is a major component concerning how people judge their hypnotic depth with the PCI-HAP. These results support the theorizing (among others) of Holroyd (2003), Weitzenhoffer (2002), Lynn and colleagues (Lynn & Rhue, 1986, 1988; Lynn & Sherman, 2000), Sheehan (1979), and Kirsch & Braffman (1999, 2001) concerning the importance of fantasy and

imagery, and hence, suggestibility (Schumaker, 1991) in understanding hypnotic depth as experienced by participants.

Total average expectancy (an average of pre-hypnotic estimated hypnotic depth and expected therapeutic efficacy and post-hypnotic therapeutic efficacy) accounted for second largest amount of the variance in the hypnotic depth scores, suggesting that the participant's expectancies are quite relevant in their experience of hypnotic depth. This result supports the theorizing of Kirsch (1985, 2000), Erickson (Erickson, Rossi, & Rossi, 1976), Holroyd (2003), and many clinicians concerning the importance of having a positive expectancy (Hammond, 1990) in reference to the experience of hypnotism.

Trance state (the hypnoidal state score) was also found to be a variable left in the regression, supporting the theorizing (among others) of Holroyd (2003), Weitzenhoffer (1989), Hilgard (1965), Barabasz and Watkins (2005), and Kihlstrom (1997) concerning the importance of alterations in experience and consciousness in self-reported hypnotic depth.

Loss of motor control, as evinced by the eye catalepsy item (the motor challenge item), was also left in the regression equation. This effect supports the theorizing of Woody, Barnier, and McConkey (2005) who suggested that hypnotism consists of a general factor and several component factors. The eye catalepsy item taps into aspects of their motor challenge factor, a factor which they suggest is different from their direct motor factor or their cognitive factor (the PCI-HAP hypnotic dream item taps into their cognitive/perceptual factor).

The Hypnotic Responsivity Index (HRI). An important final variable listed in the table to the top left of the summary score sheet of the EXCEL printout (page 4 of printout; page 30) is the hypnotic responsivity index (HRI). This is the mean HRI score and HRI percentile score averaged across the four variables: adjusted hypnoidal state score, imagoic suggestibility score, total average expectancy score, and the post-hypnotic self-reported hypnotic depth score. For several years I resisted generating this score, partially because I currently have no research data showing that it predicts response to hypnotic analgesia, therapeutic efficacy, etc.

However, clients have repeated asked me, based on the 4 domain scores (hypnoidal state, imagoic suggestibility, total expectancy, and self-reported hypnotic depth), how deeply hypnotized they were during the session. This score allows me to get an estimate of their hypnotic responsivity, and it allows me to tell the client what percentile score they are in, based on averaging the four domain scores.

Clients usually find this average score quite useful. As mentioned, I have no research data to date concerning the usefulness of this score. Because clients want to know their "average" score, this index was generated. How it may relate to Harvard (Shor & Orne, 1962) or Stanford C (Weitzenhoffer & Hilgard, 1962) total scores must await future research.

I tell the client that the PCI-HAP samples several, but not all, of the various domains associated with hypnotism. Hence, the HRI mean and percentile scores, give an estimate of the client's overall hypnotic responsivity, but may miss or overlook aspects of their hypnotic responsivity not assessed by the PCI-HAP.

The following sections will review the various pages of the PCI-HAP print-out and how the data contained therein may be useful to the therapist and the client.

Page 1: Pre-Post Assessment

This page does not need to be interpreted, since it contains only information that you typed in from the pre- and post-assessment forms. However, certain information on this page is not referenced elsewhere and needs to be reviewed with the client. The negative effects item (#7 on the Pre-Post Assessment page of the EXCEL printout) needs to be reviewed. Approximately ninety percent of the time the client will report no negative effects (Pekala, Kumar, Maurer, Elliott-Carter, Moon,& Mullen, 2009a). However, they may still report negative affect on the three PCI subdimensions (anger, sadness, and fear), which you will be able to assess once the PCI is computer scored with the EXCEL program.

If the client does report negative effects, it is important to determine if this is a state effect, such as being due to having a previous argument with someone before doing the assessment, noises outside the office which interfered with the client's hypnotic experience, and hence caused frustration which leads to the client feeling angry, etc. However, because hypnotic routines, and any relaxation-based routines for that matter, can sometimes loosen defenses, it is important to assess the possible cause(s) of any negative effects.

I have had some clients, possibly due, I believe, to their abuse and trauma background, who reported that hypnotism was associated with negative effects/symptoms and negative affects that seemed to "bubble up," so to speak, during the assessment. If this is the case, you may not want to do hypnotism with your client at this time, focusing instead on protocols to further ground and stabilize your client, i.e., breathing strategies, biofeedback assisted strategies, bibliotherapy, supportive/cognitive therapy, etc.

Evidence of negative effects in the post-assessment, in addition to the report of negative affect (anger, sadness, or fear) may suggest that hypnotism, if used, should be used rather judiciously. If the client, from their history, does report trauma (physical, emotional, or sexual abuse or neglect), you may want to give the client the DES (Dissociative Experiences Scale) (Carlson & Putnam, 1993), the CAT (Child Abuse and Trauma) scale (Sanders & Becker-Lausen, 1995), and the ICMI (Inventory of Childhood Memories and Imaginings; Wilson & Barber, 1983) before doing a hypnotic assessment, to get a better idea as to the intensity/frequency of their trauma.

Use of these inventories can help determine if your client may be suffering from a dissociative disorder, for which hypnotism, although possibly quite useful to the client once the client is stabilized, should initially be used judiciously, due to the mythos of "loss of control" associated with hypnotism. If this loss of control issue is a major one in the initial therapy encounter, I will many times use biofeedback or even visualization, which do not have a loss of control motif usually associated with hypnotism. The use of EMG, ST (skin temperature), and SC (skin conductance) modalities are usually quite helpful with such clients, since biofeedback employs a self-control motif associated with it. (Before doing hypnotism, I will usually do a basic relaxation protocol called the body scan - progressive relaxation but without the tensing.)

Page 2: PCI Data Sheet

"Item Numbers" (far left column): The far left column on page 2 of the EXCEL printout (page 28) shows the 26 (sub)dimensions of the PCI and the item numbers for the various items composing the (sub)dimensions. Items with an asterisk need to be reversed before being scored. This section was added because sometimes clients will miscomplete various items of the PCI. This column allows the reviewer to pull out a copy of the PCI and see for which items the client obtained the score that they did. As an example, a colleague, when talking the PCI-HAP, obtained a high score for one of the fear items, and yet had scores of "0" for the other two negative affect dimensions (sadness and anger). He also had a zero score for the second fear

item. He reported, when queried, that his high score for the one fear item was a mistake. His PCI-HAP was rescored with this item changed.

"Circled" Column: This is the actual raw scores from the PCI that you type into the EXCEL program.

"Score" Column: This column reverses those items of the PCI that need to be reversed before the (sub)dimensions scores are computed.

"Intensity" Column: This column lists the intensity for the various dimensions and subdimensions of the PCI in terms of their raw scores. Scores range from "0" to "6," with scores of "0" indicating "none or little," to scores of "6," indicating "much or complete."

"Percentile Scores" Column: This column lists the comparative percentile scores, normed against a data base using the Harvard. These percentile scores are based on the PCI (Pekala, 1991b) given in reference to the Harvard (see Pekala, 1991a, pp. 376-379). Unpublished data from Spencer, Kumar, Pekala, & Conte (2000) comparing the PCI (sub)dimension scores between the Harvard and the PCI-HAP suggested nonsignificant differences between both assessments for all subdimensions except imagery amount, imagery vividness, and love. Hence, use of the percentile scores for the graphs generated by EXCEL for all PCI subdimensions (and associated major dimensions) except the above can be assumed to be reasonably correct, since the PCI scores for these (sub)dimensions were not significantly different from one another.

The percentile scores for imagery amount, imagery vividness, and love (and their associated major dimensions) have been statistically corrected to control for this overinflation by comparing the data bases of Forbes and Pekala (1993) and Pekala and Maurer (2008), and statistically reducing the overinflation corresponding to the differences in the means between these variables. (See Table 2, page 34, for the statistical correction analyses.)

Because the Harvard does not have a hypnotic dream item, and the PCI-HAP does, individuals taking the PCI-HAP are more likely to have a significantly higher percentage of imagery vividness and imagery amount (and also love) than the Harvard. Consequently, the raw scores from the PCI-HAP for these dimensions have been statistically reduced to control of the overinflation of the percentile scores due to the above, and corresponding percentile rates recomputed due to this overflation. If this was not done, the scores for imagery amount and vividness and love would indicate higher percentile rates than should be the case.

RI (Reliability Index) Score: (right side of this page, below "hypnoidal state" score)

The reliability index score is an important score to review, and should be examined before reviewing the hypnoidal state score, and the PCI (sub)dimension intensity scores. The reliability index score is based on 5 pairs of similar or identical items embedded in the PCI. The score represents the average absolute difference for these 5 reliability items. A score of "0" indicates perfect agreement for these 5 items; a score of "6" "perfect" disagreement. If an individual were completing the PCI completely randomly, as this might be done many, many times in a Monte Carlo experiment, the resulting RI score would be 2.29.

Hence, scores greater than 2.30 are considered unreliable and scores between 2.00 and 2.29, of marginal reliability (my interpretation of what I consider "marginal"). Scores 2.00 or less are considered reliable (again, my interpretation, based on analyses using different cut-off points, i.e. 1.8, 1.9, 2.0, etc.). If the RI score is greater than 2.29, a hypnoidal state score is not listed in

the EXCEL print-out. Neither are the PCI raw and percentile (sub)dimensions graphed, nor is the trance typology profile graphed. (If a score is unreliable, it cannot be considered to be valid.)

The actual reliability difference scores for these 5 pairs of items are in the bottom middle of this page in case you are interested in seeing which items were completed unreliably. On occasion I have had a client or research participant check the wrong end of the scale for a particular item, i.e. reporting great fear, while the other fear item (from the PCI) was marked a "0." If your client does score in the unreliable range, you might ask him or her if they had trouble completing the instrument. The PCI has a 12^{th} grade reading level, and individuals who have attained less than that level of reading comprehension may miscomplete the PCI.

If the PCI is unreliable, you may still use the information obtained for the pre- and post-assessment to get an idea as to how hypnotically responsive your client may be, especially from the srHD (self-reported Hypnotic Depth) score. The srHD score correlates .48 with the HS (hypnoidal state) score (Pekala et al., 2009c). This score, used in conjunction with the imagoic suggestibility score, and the therapeutic expectancy score, can still give you some idea as to your client's hypnotic responsivity.

Scores obtained from the PCI-HAP:

The PCI-HAP generates a variety of variables when it is administered. Tables 3 and 4 (pages 35-36) list the means and standard deviations for the variables and the correlation matrix of the variables, respectively. These means and correlations are from a sample of drug and alcohol users where I work at a VA hospital (Pekala et al., 2009c). The data are based on a highly motivated sample, very interested in using self-hypnosis for their drug and alcohol addiction. Additionally, they had not been pre-screened concerning how they might respond to a basic relaxation protocol.

The Hypnoidal State (HS) score: This is the score listed on the right hand side of the page 2 of the EXCEL scoring protocol (page 28) , under the Trance Typology Profile graph in the upper right hand side of the page. This score gives you a measure of the client's hypnoidal state, i.e., it is an overall measure of "trance" or altered state composite effects. It is termed a hypnoidal depth score and it is also called a predicted Harvard Group Scale (pHGS) score, since this score is based on a regression equation taken from Pekala & Kumar (1987) that correlates about .60 with the Harvard Scale score across several studies (Forbes & Pekala, 1993; Pekala & Kumar, 1984, 1987). Table 5 (page 38) lists the regression equation used to compute this score. To explain, if you took your client's raw scores for these 10 (sub)dimensions, multiplied by its corresponding coefficient, and added up these 10 numbers, plus the constant of 4.51, you would arrive at the hypnoidal state score listed in the EXCEL printout.

Hypnoidal state (HS) scores range from: 1.00-3.00: Nonhypnotized or only a very mild hypnoidal state; 3.01-5.00: mild hypnoidal state; 5.01-7.00: Moderate hypnoidal state; 7.01-9.00+: high hypnoidal state.

Table 6 (page 39) lists the pHGS (hypnoidal state) score and its corresponding percentile score, when using the data base of the PCI given in reference to the Harvard. Notice that a raw score of about 5.0 is at the 30 percentile level and a raw score of 7.0 is at the 70th percentile level. Hence, approximately 40% of all participants will score between 5 and 7. Figure 1 (page 40) graphs the distribution, upon which the aforementioned distribution is based.

I have also listed a second distribution in Figure 2 (page 41) , which is the distribution of the pHGS scores in reference to a data base obtained from the VA hospital where I work. For this data base, the instrument given was the PCI-HAP, and the subjects were drug and alcohol users. Notice that

this distribution is less skewed than the prior one; and a score of about 5.0 is closer to the 50th percentile.

The lowest possible hypnoidal state score is -0.71 and the highest possible hypnoidal state score is 11.77. However, as you can see from the Table 6 (page 39), the lowest pHGS score obtained out of the 184 participants was 1.84, and the highest score obtained with this data base was 9.44. By knowing the aforementioned, you will have a better idea as to how your client's hypnoidal state score compares with population norms.

Trance Typology Profile: This graph in the upper right of the page 2 of the EXCEL scoring protocol (page 28) shows the 9 hypnotic types, using the discriminant function algorithm taken from Pekala and Forbes (1997). The 9 types are listed on the x axis and the discriminant function coefficient scores are listed on the y axis. The lower center section of page 2 of the EXCEL protocol shows the unstandardized discriminant function coefficients from which this table is generated. The particular "type" to which the client gets assigned (the one or two point code) is listed in the center of this page, under "Trance Typology Profile." Table 7 (page 42) lists the 9 hypnotic types with some distinguishing characteristics

A visualizer is hence assigned to be a "type 5," while a classic low is assigned a "type 1." What you need to realize is if the scores are very close to one another, the client is probably a mix of those particular type(s), and that is why the top two scores are coded together (if they are within five percent of one another).

The way discriminant function analysis works is that the highest score listed determines the type to which the client gets assigned. If the top two scores are within 5% of each other, the client is assigned a two-point score. If there are more than 2 scores within 5% of each other, the client is still only assigned to the two types; types with the highest two scores. If the 3 or 4 top scores are all within 5% of each other, realize that the client is probably a mix of these types, even though only 2 code types will be listed.

What's important to realize about trance typology is that assignment to a particular type may sometimes affect interpretation of the HS score, or possibly the whole profile for that matter.

I have listed below some information concerning the particular types:

Classic lows: Making up about 8% of the population (Pekala & Kumar, 2000), classic lows have a paradoxical response to hypnotism, and tense up more than if they are just sitting quietly. I have only worked with a few classic lows (in psychotherapy; less, using hypnotism). They may be overcontrolled, fearful of letting go, and/or may have primitive defenses. Whereas the relaxed lows are the "unable," the classic lows may be considered the "unwilling."

Something unusual is "going on" with the classic lows to generate their low scores. This may be a state condition (due to a transient condition, such as intense back pain) or a trait function (an overcontrolled character structure). One classic low obtained this designation, I believe, due to the chronic back pain he was experiencing during the PCI-HAP assessment. I had another person who was overcontrolled in his life and could not "let go." I have had clients test out as classic lows because the hypnotic assessment, I believe, loosened defenses, which due to these clients' past abuse or trauma, resulted in a "non-letting go" response. Most classic lows, if the type designation appears to be due to trait, and not a state, effects, do not appear very interested in further exploring their "classic lowness," and they will typically not want to pursue hypnotism!

If your client tests out to be a classic low, it is important to ask if him or her if their reported experience was due to state effects, i.e. pain somewhere in the body, an argument with someone

just before the session which carried over into the hypnotic assessment, etc. Because the PCI is a state instrument, it will more easily "pick up" events from the immediate past that carry over into the hypnotic assessment.

Possibly the fear of "letting go" associated with hypnotism, causes the classic low to tense up instead of relaxing. Figure 3 (page 43) shows a graph of the hypnoidal state of low, low-mediums, high-mediums, and highs (as determined by the Harvard) and their hypnoidal state scores for 4 stimulus conditions: eyes closed sitting quietly, deep abdominal breathing, progressive relaxation, and hypnosis (as assessed by the Harvard). What is important to realize from this graph is the group of lows as a whole (Harvard scores of 0 to 4), actually did better with progressive relaxation than hypnosis. Progressive relaxation, because the client tenses and then relaxes his own muscles, allows the client to be more in control of the intervention, than when doing hypnotism, which has an ostensible loss-of-control motif. Biofeedback (EMG;, skin temperature, and skin conductance), which stress a self-control motif, may be especially useful for this particular type.

Relaxed lows: Making up about 13% of the population, relaxed lows get relaxed but they do not usually have much in the way of alterations in experience or state of awareness associated with hypnosis. These individuals can still benefit from relaxation-based strategies, but a relaxation tape may be just as good as a self-hypnosis tape.

Nondialoging Mediums: The nondialoging and dialoging mediums make up 30% of the nine hypnotic types. The nondialoging mediums account for about 7.4% of the total. They are similar to dialoging mediums except for having less internal dialogue. With this group and especially the dialoging mediums, you want to see what (sub)dimensions on the next page ("PCI (sub)dimension scores" sheet) have high scores that you may use in helping tailor hypnotic suggestions to the client's hypnotic strengths.

Dialoging Mediums: The dialoging mediums are similar to the nondialoging mediums except they have more internal dialogue. This group accounts for about 22% of the total. It is important to check this group's PCI internal dialogue score. Sometimes the incessant chatter that runs through our minds can be a distraction to paying attention to the hypnotist's voice. If this score is a rather high percentile, you may want to add suggestions that the subject can just let that chatter move into the background of consciousness or suggest that this is just the normal mind's background noise and it will not be distracting, hence, trying to normalize the experience instead of trying to decrease it. Breathing strategies are also useful with this group to try to reduce the chatter via breathing.

Visualizers: Visualizers are a very interesting group. They have the highest level of visual imagery of the nine groups; they also have the highest level of self-awareness and most intact memory after the classic and relaxed lows. Visualizers have a lower hypnoidal state score that than of the fantasy and classic highs. As you can see from Table 7 (page 42), they score at least a point lower on the hypnoidal state score than the classic and fantasy highs. They make up about 10% of the population. (See Table 8, page 44.)

Visualizers usually also do not report the drops in memory, self-awareness, rationality, and volitional control that the classic and fantasy highs typically report. However, the visualizers and the fantasy highs are the two best groups to work with hypnotically of the nine groups, in my opinion. This is because of their imagery vividness and amount, and their ability, usually, to use that imagery vividness/amount to effect change. If a person is a visualizer, check their scores for the hypnotic dream. A person usually turns out to be a visualizer because of high scores on the PCI imagery vividness and amount subdimensions. Is their iS (imagoic suggestibility) score as high as their PCI imagery vividness score? Whereas the PCI imagery vividness/amount scores

are uncued (the client generates such imagery without being asked to do so), the IS score is a cued score; i.e., the client is asked to go on a "vacation and have a wonderful and relaxing time."

Visualizers do not report the alterations in consciousness, state of awareness, and experience as much as the other high types (classic and fantasy highs). Therapeutically, I believe there are no differences in the success rates between the visualizers and the fantasy highs that I achieve in terms of using hypnotism with these groups. I also tell the visualizers that they usually underestimate their level or trance and hence may feel that they were not "hypnotized" as they expected.

It is also important to evaluate visualizers in reference to their IS score. A visualizer who has a high PCI imagery vividness score, but a low IS score, may be able to spontaneously generate visual imagery on their own, but have some difficulty when asked to do so by the hypnotist. This is where a hypnotic deepening, to obtain a second sample of the client's hypnotic abilities, is helpful. You have to remember that the PCI-HAP is a state instrument, and not the usual trait instrument that psychologists are used to working with. As a consequence, the PCI-HAP scores serve as a "starting point" for setting up a hypnotic intervention, but these scores may change due to further "sampling" of the client's state of mind during hypnotic interventions.

Rational Hi-Mediums: These individuals are similar to dialoging high-mediums except for less internal dialogue and more rationality. This type makes up about 7% of the population. Rational high-mediums typically are a little more particular about the nature of the suggestions that you give them. They appear to have a stronger need to have things coherent and internally consistent. Both of the hi-medium types tend to have hypnoidal state scores almost 2 points higher than the medium types. Consequently, they typically tend to report feeling "more hypnotized" than the medium types, and less work is needed to get them to "buy into" using hypnotism.

Dialoging Hi-Mediums: This type is similar to rational high-mediums except for more internal dialogue and less rationality. This type makes up about 10% of the population. As with the dialoging mediums, the internal chatter can be distracting to this type, although less so than the dialoging mediums because of a somewhat higher hypnoidal state score. Look to see which PCI (sub)dimensions may be useful to you in generating suggestions congruent with the hypnotic processes activated.

Fantasy Highs: Fantasy highs are a wonderful group with whom to work. They usually have both the alteration in state of awareness and experience that leads them to believe that they were hypnotized, and they usually also have high imagoic suggestibility (check their IS score). Of all the nine typology types, they can usually be helped with self-hypnosis training, provided they are motivated and practice. Sometimes however, their ability comes "too easily" for them, and although they have the hypnotic talent, they do not have the motivation to practice the self-hypnosis CDs/audiotapes that are cut for them.

Classic Highs: Classic Highs are an interesting group. They make up about 13% of the total when the PCI was given in reference to 852 participants (Pekala & Kumar, 2000). (See Table 8, page 44) for percentages of the 9 hypnotic types.) However, I have seen very, very few in my private practice, and only two when giving the PCI-HAP to groups of individuals for training purposes, who I felt had not fallen asleep during the PCI-HAP administration. Even of those individuals that I have seen in my private practice, for those that score as a classic high, I believe that most of them may have fallen asleep during the individual assessment. (If I, or the client, feel they have fallen asleep during an individual administration of the PCI-HAP, I usually do not have they complete the PCI-HAP, since it would be invalid. However, when the PCI-HAP is administered in a group setting, it is more difficult to ascertain this and I usually encourage the

client to complete the PCI-HAP anyway.) I suspect that a sizable percentage of these individuals probably fall asleep during all or part of the sitting quietly period of the PCI-HAP.

If a person tests out a be a classic high, you need to go the EXCEL printout Summary Sheet (page 4 of printout, page 30) and peruse their Wakefulness Total Score in the lower right of the page. This score gives the clinician an idea about how awake the client may have been, and is the sum of the finger raising item of the post-assessment (1= raised finger; 0=did not raise finger), and the sleep item of the post-assessment ("did not fall asleep" = 1; "yes, fell asleep" = 0). A WTS score of "2" suggests that the client was awake (behaviorally and phenomenologically), a score "0" strongly suggests that the client was asleep (both behaviorally and phenomenologically) and all PCI-HAP testing results are SUSPECT!

If the person is a classic high and the WTS score is less than 2, the client may have been sleeping, or drifted in and out of sleep during the PCI-HAP assessment. You might want to do a second PCI-HAP and make sure the client remains awake, while concurrently testing the client during the protocol (asking them to raise their finger if they hear you) to make sure they are awake. I have found that when I do a second assessment, from the several clients I have seen in my private practice that have done a second PCI-HAP, they do not test out to be a classic high if they have not fallen asleep.

I do believe that there may be some individuals who really are classic highs, and not just sleeping, or drifting in and out of sleep. These may be individuals that Deirdra Barrett (1990, 1996), has designated, dissociaters. They are individuals who appear to become amnestic during hypnotism. The late Fred Evans (1977) has published an interesting book chapter on the relationship between sleep and hypnosis. Interested individuals are encouraged to procure this chapter. I have not yet subsequently worked with someone who I felt was really awake when they obtained the classic high designation. This is an area that awaits future research!

Page 3: PCI (Sub)Dimension Scores:

This page lists the client's raw and percentile scores for the PCI major dimensions on the left and the minor dimensions on the right. It is important to look at both the raw and percentile scores when determining the possible usefulness of this (sub)dimension in generating process congruent suggestions. This is due to the fact that a client may have a PCI minor dimension percentile score of 60% for anger and yet has a "0" raw score for this dimension, due to the fact that 60% of all individuals report no anger during hypnotism.

By looking at both the raw and percentile scores, you will be able to decide just how significant the client's score is for a given (sub)dimension. Table 9 (page 45) shows the 12 major dimensions that was developed by Joan Hageman for use with her dissertation research. It gives a good overview of each of the major dimensions and also enumerates the subdimensions, if the dimension is composed of such subdimensions.

The following section lists each (sub)dimension and how this information may be useful to you in helping to collaboratively generate process congruent suggestions for your client.

Volitional control: This is a measure of the "classic suggestion effect" (Weitzenhoffer, 1974), indicating the extent to which the client feels there is a loss of control over his or her experience. A low percentile score suggests that the client feels he or she did not have control over their phenomenological experience, a high score suggests the opposite. If this percentile score is high, the client may not be able to let go, may have fears of losing control, or because of their current situation (having just come from a fight with their fiancée), may really have no problems with "letting go," but just could not do so this particular session. If the client appears to be a

high volitional control person, you as the clinician might be well to not suggest "letting go" in the hypnotic deepening, or make sure that suggestions of safety and security are suggested if the client feels including such suggestions ("letting go," that is) would not be deleterious.

This fear of "letting go" may be one of the major reasons why the public remains fearful of hypnotism. But many individuals may not endorse such feelings, and yet may still report alterations in experience, consciousness, etc. during hypnotism. Very high scores (80 percentile and above) and very low scores (20 percentile and below) should probably be addressed with the client to determine their thoughts about "letting go."

This score needs to be evaluated with the "Classic Suggestion Effect Total Score" in the lower left corner of the summary page. See the section below concerning this.

Rationality: Rationality assesses whether the participant's thinking is clear and distinct or rational and easy to comprehend, or is confused and muddled or nonrational and very hard to comprehend during the hypnotic assessment. Rationality is actually negatively correlated with the pHGS score, meaning the lower the rationality score, the higher the pHGS score. In the regression equation for the computation of the hypnoidal state score, it ends with a positive sign, even though the Pearson *r* is negative. This is because it is probably functioning as a "suppressor variable" (Grimm & Yarnold, 1995) in this equation, i.e. more highly correlated with the other independent variables than the criterion variable. That is, a suppressor variable allows for more of the variance to be accounted for than would otherwise be the case: "the effect of a suppressor variable is to partial out of the other predictors' variance that is irrelevant to the criterion, resulting in larger relationships with, the prediction of, the criterion" (p. 63).

Memory: This PCI major dimension assesses the subjective perception that the participant can remember just about everything that they experienced or whether they are not able to remember whatever they experienced. The more highly hypnotizable types, in general, report reductions in this dimension the more deeply hypnotized they feel themselves to be. However, it should be pointed out that visualizers and the rational high-mediums, tend not to have such drops, as much as the other "high" types.

Self-Awareness: Self-awareness assesses the extent to which the participant is aware of being aware of their self or whether the participant looses consciousness of himself or is not aware of being aware of himself. Sometimes drops in self-awareness can be somewhat scary to the client and yet sometimes that sense of letting go as one falls off to sleep can be deeply relaxing. Hence, I would recommend asking the client about this if their percentile scores are high (above the 80 percentile) or low (below the 20 percentile).

Altered State of Awareness: This dimension assesses whether the participant feels himself to be in an "extraordinarily unusual and nonordinary state of awareness" or if their state of consciousness is not any different than usual. High hypnotizable types (those types who score high on standardized hypnotic susceptibility tests like the Harvard or the Stanford) typically report high scores on this dimension. Low hypnotizable types typically report little in the alteration of consciousness. Here again, as with the prior dimensions, I would ask the client to comment on their experience if their scores were high or low, to gain some insight into how they feel about this issue.

One doesn't necessarily need to have alterations in experience for hypnotism to be helpful. Visualizers tend to have less alterations in experience than the fantasy highs. Finding out the meaning of such experiences and what they mean to the client may be quite important.

Some ultraconservative types may believe that such an altered state is something that must be fought against, while more "open to experience" types will be quite excited to have such experiences. Obviously, high scores on this dimension suggest the client may "buy into" experiencing hypnotism, especially if positive affect levels are up and there is little in the way of negative affect.

Internal Dialogue: This is an interesting PCI dimension. Internal dialogue assesses the extent to which the participant is talking silently to himself a lot or did not engage in any silent talking to the self at all. Internal dialogue is usually found to be uncorrelated (or only lowly correlated) with the other PCI major dimensions. This is because, I believe, ones internal chatter is on "autopilot," so to speak, and continues regardless of what we do or experience. For some types, like the visualizers or the fantasy highs, high levels of internal dialogue do not appear to have any negative effect on level or trance. For the less hypnotically responsive, this can be a "sticking point" since the client may have a hard time focusing on the therapist due to the racing thoughts within.

I usually show the client a variety of breathing exercises before I begin relaxation-based training, which is usually before I do a hypnotic assessment. Breathing exercises and basic relaxation exercises, such as progressive relaxation and a "body scan" (progressive relaxation but without the tensing), invariably precede a hypnotic assessment. Many times practice of such breathing exercises will physiologically relax the client, which will then have an impact on the amount of internal dialogue occurring. Additionally, I have also used meditation as a way of helping the client become aware of the thoughts, and through a process of extinction, try to "let go" of those thoughts. Finally, "normalizing" such thoughts and having them become a background or backdrop to consciousness, can help "legitimize" such thoughts and hence allow them to become less distracting by letting them become a background to consciousness.

Arousal: This is a measure of subjective muscle tension. This is an important dimension to assess, especially if the srHD score or the hypnoidal state score is low. If muscle tension levels are high, such muscle tension levels may make it difficult for the client to relax sufficiently to move into a hypnotic state. I have also had pain patients who were not able to experience hypnotism sufficiently to get the subjective effects that they might have had, had they not been in so much pain. If his score is high, try to ascertain from the client the reasons. If the high arousal score is a function of state influences, you may want to redo the PCI-HAP at a later time.

Positive Affect (since the next five dimensions are major dimensions of several subdimensions, see the rationales for the subdimensions of which they are composed). A recently published paper describes the presence of positive and negative affect during the PCI-HAP (Pekala et al., 2009a). Figure 4 (page 46) shows a histogram of the level of positive affect (summing across the three dimensions of joy, love, and sexual excitement). It is not unusual for most clients to experience some positive affect during the administration of the PCI-HAP, and the positive affect is usually greater than any negative affect that is reported. Regression analysis found that positive affect was found to be a function of the vividness of the hypnotic dream during the PCI-HAP and both self-reported hypnotic depth and hypnoidal state. (See Table 10, page 47).

Negative Affect: (see below) Figure 5 (page 48) shows a histogram of the levels of negative affect associated with the PCI-HAP (averaging across anger, sadness, and fear). Whereas many individuals will report no negative affect during the PCI-HAP, some will. It is important to ascertain, when the PCI-HAP is reviewed, what may be the source of that negative affect. Is it something situational, such as an earlier argument that was re-remembered during the

assessment, or the "bubbling up" of negative affect due to trauma or abuse from childhood or later.

Altered Experience: (see below)

Imagery: (see below)

Attention: (see below)

Joy: This subdimension measures the extent to which the client feels joyful. Feelings of joy are not unusual, especially if the client has a fairly vivid hypnotic dream. High scores of this subdimension suggests that practice of hypnotism may be associated with positive affect, hence making such practice reinforcing. I usually regard high scores for joy (about 3.0), in the absence of sexual excitement, as a good sign for subsequent practice of self-hypnosis strategies.

Sexual Excitement: It is not unusual to find high scores on this dimension for males; especially if they have had fairly vivid imagery during the hypnotic dream. The summary page includes a "positive practice" score. This score is the sum of: 2 times the raw score for the joy item plus the love item raw score minus 3 times the raw score of the sexual excitement item, all divided by 2. However, if the sexual excitement raw score item is greater than 1.0 or the joy raw score is less than 2.0, then the PPS is 0.

Love: Love is sometimes reported by individuals who obtain high scores for the hypnotic dream item. High scores are less likely to occur with love than joy, but if joy scores are high, it is not unusual to have some elevations on love.

Anger: As one of the three negative affects assessed by the PCI negative affect dimension, this is a useful dimension to review. Fifty percent of individuals will obtain a zero score on this dimension. If a score greater than 0 is obtained, then it is usually related to some situational variable contiguous in time or space to the PCI-HAP administration. As an example, the client just had a fight with their spouse, and he is still ruminating about it. However, sometimes clients can miscomplete an item or two on the PCI, and yet still be reliable (an RI index of 2.3 or less). Review with the client those negative affect scores for which they obtained a greater than zero score and see if they can determine why this happened. One can obtain a greater than zero and sometimes even high scores on this dimension (and the other two subdimensions, as well) even though the "negative effects" item fro the pre-assessment will be answered "no."

Once in a while (approximately one out of 50 to a hundred clients) I will have a patient or client, whose high score (above 4.0) is related to an unpleasant memory surfacing. This usually does not happen with nontrauma patients, but can happen with trauma patients, especially if they have recently been working on such issues. In such cases, I may decide that because of high scores on this subdimension (especially if the other two subdimensions are elevated) that I will not begin self-hypnosis training with this client until they are better stabilized, and/or until we have worked through the affect associated with the surfacing memory.

Sadness: As with anger, high scores suggest the need to dialogue with the client about the reason for the sadness.

Fear: As with sadness and anger high scores suggest the need to dialogue with the client about the reason for the fear.

Altered Body Image: This is one of the four subdimensions of the altered experience major dimension. A high score (80 percentile) suggests that hypnosis may be useful to such individuals in helping them modify their perceptions of their body image.

Altered Time Sense: As another one of the four subdimensions of altered experience, high scores of this dimension may allow you as the therapist to suggest time dilation, having a 20 minute hypnosis session seem like several hours of restful sleep to the client.

Altered Perception: This is another one of the subdimensions of altered experience. I do not necessarily find this subdimension very useful, possibly because clients are asked to assess their environment around them when their eyes are closed, something the client may not be able to do well with eye closure.

Altered Meaning: High scores on this subdimension suggests that the therapist may use hypnotism to alter the meaning of events; decreasing the meaning of negative affect associated with traumatic events, and augmenting spiritual or existential meaning for the client.

Imagery Amount: This is a measure of the amount of spontaneous (or client directed) imagery generated by the client. High scores may suggest the use of imagoic strategies with the client. (Remember to also check the imagoic suggestibility score, since this may be different from the PCI imagery amount and vividness scores.)

Imagery Vividness: This is the second measure of imagery measured by the PCI. High scores of this subdimension suggest high spontaneous (or client directed) imagery vividness. This score is usually correlated with the imagoic suggestibility score. I believe that many clients who have a vivid hypnotic dream, when suggested, will use the 2 minute sitting quietly period, to return to that dream, or use their imagery abilities to conjure up some other imagoic reality.

Absorption: This subdimension of attention, if high, suggests that the client can more easily become absorbed in their suggested experiences during hypnotism. Although not always high in someone who has a high pHGS score, it suggests another hypnotic talent to utilize.

Direction of Attention: This subdimension I have not found particularly useful in generating hypnotic interventions with the client. It tells you how inner versus outer directed the client is concerning their subjective experience.

Page 4: Summary Page (page 30):

This page lists the major scores obtained by the PCI-HAP and several minor scores. Once reviewing the RI score, this is the page I turn to the get an idea of the client's major hypnotic talents. Before reviewing the top of this page with its four sets of scores, and summary score, the HR index, I recommend looking at the validity index in the lower right hand of the summary sheet. Some clients, especially when tested in small groups, will be unresponsive (possibly fall asleep) during all or part of the assessment protocol. The Wakefulness Total Score (WTS) allows you to get some idea as to whether the client was unresponsive during this part of the assessment.

A WTS score of "2' suggests that the client was awake (behaviorally and phenomenologically), a score "0" strongly suggests that the client was unresponsive and all PCI-HAP testing results are SUSPECT! A behavioral score of "0" by itself (the client did not raise their finger when asked to do so) may also mean that the client was unresponsive; it should be evaluated in reference to the phenomenological score. I believe the phenomenological score is less predictive of invalidity than the behavioral score, although both should be reviewed and

discussed is the client, especially if it seems like the client may have fallen asleep. The WTS score should also be evaluated against the trance typology profile. I believe many, but not all, of the classic highs, are actually asleep during all or part of the hypnotic assessment.

If the client did not raise their finger when asked to do so, this suggests (although not 100% of the time) that the client probably fell asleep during this part of the assessment, and may have fallen asleep during other parts as well. (I recently had a client believe that if he raised his finger, this meant to him that he has lost control and consequently, being fearful of such loss of control, refused to raise his finger for this reason.) This score may also mean that the client is a dissociater, per Deirdre Barrett's (1990, 1996) research, and hence needs to be further discussed with the client.

If the reliability index is less than 2.3 and the validity (WTS) index is greater than one (especially if this is due to a score of "1" for the finger raising item), I will usually proceed with reviewing with the client their results.

The Hypnoidal State Score (HSS) is the overall measure of "trance depth", also labeled a hypnoidal state score, or a predicted Harvard Group Scale (pHGS) score that is based on a regression equation (Pekala & Kumar, 1987) in predicting the total Harvard Group Scale score from the PCI (sub)dimensions. Research suggests it correlates about .60 with Harvard Scale score across several studies. Score ranges are also follows: 1.00-3.00: Non-hypnotizable or only a very mildly hypnoidal state; 3.01-5.00: Mild hypnoidal state; 5.01-7.00: Moderately hypnoidal state; 7.01 - 9.00+: Highly hypnoidal state.

This score allows you to determine where your client's level of "trance depth" lies in reference to that of others (normed against the Harvard). Remember that this score represents one of the major aspects that clients use to evaluate if (and how much) they were hypnotized. It is not the only major measure; also important are the imagoic suggestibility score, the expectancy score, and the self-reported hypnotic depth score. This score represents, I believe, Weitzenhoffer's (2002) definition of hypnosis, the subjective state the client feels himself to be in, due to the hypnotic intervention. Visualizers do not typically score as high on this dimension as the other highly hypnotizable types (fantasy highs, classic highs). Consequently, if a person says that they do not think that they were hypnotized, because they felt they did not enter an "altered state of consciousness," let the client know that this is only one of several aspects associated with being hypnotized. Moderate to high scores on only one of the 4 variables listed on the table at the top of the page are usually sufficient to begin self-hypnosis training.

The Adjusted Hypnoidal State Score (aHSS) is the hypnoidal State Score (HSS) that has been multiplied by 1.11. Because this score typically runs between "1" and "9," and the other scores in the table run from 1 to 10, the aHS score allows this variable to be evaluated comparatively to that of the other variables.

The Imagoic Suggestibility Score (ISS) is the vividness of the client's visual imagery during the hypnotic dream of the PCI-HAP. This is an important variable, and regression analyses suggests that it accounts for about 40% of the relative variance associated with ones perception of being hypnotized (the self-reported hypnotic depth score). A high score on either this variable or a high aHS score will usually lead the client into believing (making the attribution) that they were hypnotized.

Table 11 (page 49 shows an interesting relationship between imagery vividness before hypnotism, the hypnoidal state score, and the imagoic suggestibility score. Most clinicians believe that hypnotism augments imagery vividness (assessed before hypnotism). Figure 6

and 7 (pages 50-51) attests to a positive correlations among hypnoidal state, imagery vividness before hypnotism, and imagoic suggestibility.

Average Total Expectancy Score (ATES): This is the client's averaged pre- and post-hypnotic expectancy scores. It is the average of the two pre-hypnotic expectancy scores: the pre-hypnotic estimated hypnotic depth score and the pre-hypnotic therapeutic expectancy score plus the post-hypnotic therapeutic expectancy score divided by 2. It represents the average expectancy score across the pre- and post-hypnotic conditions.

The Post-Hypnosis Self-Reported Hypnotic Depth Score (srHDS) gives you a measure of how deeply hypnotized the client felt themselves to be. I believe this is a very important clinical measure. If the client believes that they were not hypnotized, what are the odds that they will practice self-hypnosis, or be open to hypnotic interventions? Fortunately, of these four aforementioned variables, this is the variable that appears the easiest to slightly increase. After doing a PCI-HAP, I will typically follow this with a hypnotic deepening routine. This second intervention, wherein I try to deepen the client's srHD score, gives me a second "sample" of the hypnotic processes/contents activated by hypnotism. Typically, by increasing the hypnotic induction time, incorporating breathing strategies, and increasing the rapport with your client, this variable can be increased by a point or two.

Recent research (Pekala, Kumar, & Maurer, Elliott-Carter, Moon, and Mullen, 2009b,c) suggests that the srHD score is a function of several PCI-HAP variables: the hypnoidal state score, the imagoic suggestibility score, expected therapeutic efficacy, expected hypnotic depth score, and the eye catalepsy item. A multiple R of .78 (accounting for about 60% of the variance) was generated when predicting the srHD score from the PCI-HAP pre- and post-assessment scores and the hypnoidal state (pHGS) score. (See Table 1, page 33.)

In other words, a person's imagery vividness accounted for the greatest percentage of the relative variance, followed by expectancy. The client's hypnoidal state (their "trance depth") was also a significant variable, as was whether the client was able to open their eyes in response to the eye catalepsy item. These effects appear to be additive and not (statistically) interactive. Figures 8 and 9 (pages 52-53) show self-reported hypnotic depth as a function of pre-hypnotic combined expectancy, hypnoidal state, imagoic suggestibility, and passage/failure of the eye catalepsy item. As the reader can see higher scores of these variables are associated with increased self-reported hypnotic depth.

Hypnotic Responsivity Index (HRI): This is the mean score and percentile score averaged across the four variables: adjusted hypnoidal state score, imagoic suggestibility score, average total expectancy score, and the post-hypnotic self-reported hypnotic depth score. No research is currently available on the usefulness of this score. It was generated because my private clients would repeatedly ask me how hypnotizable they were, especially if there was significant variability in their summary scores listed at the top of page 4 of the EXCEL print-out (page 30).

Caveat concerning the variables below:

The scores below represent scores that may be useful in terms of understanding the client's hypnotic talents. There is no research data available on the variables below at this time, although the reader can see that the rationales of these variables are based on common sense and interpretations consistent with what the variables purport to measure.

The Pre-Post Hypnotic Depth Difference Score (HDDS) is the difference score between how hypnotizable the client thought they were going to be before hypnotism, versus how hypnotized

they felt they became during the PCI-HAP. A negative score may indicate a negative response expectancy, and one should try to reverse this during the subsequent hypnotic deepening procedure, or the next hypnotic intervention. If there is a decreased pre-to-post HDD score, I typically ask the client about this. Were they disappointed that they did not get as hypnotized as they thought they would? By determining the client's attributions concerning this score, and also the TEDS score (see below), the clinician can better determine the client's expectancies for subsequent hypnotism, and what may need to be done to try to alter those expectancies for lows.

The Pre-Post Therapeutic Expectancy Differences Score (TEDS) is the difference between how helpful the client thought hypnotism would be (before the assessment), versus how helpful they feel it is going to be, after the hypnotic assessment. A negative expectancy score may indicate a negative therapeutic expectancy to subsequent hypnotism, and should be discussed. Recent research (Pekala et al., 2009c), suggests that both pre-hypnotic estimated hypnotic depth, and pre-hypnotic expected therapeutic efficacy add separate (statistically independent) and relatively equal variances to the perception of being hypnotized (about 15% of the relative variance for each.) Reviewing with the client their attributions concerning this and the previous item, can help correct any misconceptions and hopefully increase therapeutic response.

The Hypnotic Depth/Adjusted Hypnoidal State Discrepancy Ratio (HDDR) is the ratio between the post-hypnosis self-reported Hypnotic Depth Score and the adjusted Hypnoidal State Score (this score is multiplied by 1.11 since it runs from 1 to 9; the srHD score runs from 1 to 10). A ratio of greater than 1.0 indicates that the client is overestimating his hypnotic depth (based on his hypnoidal state score), while a ratio of less than 1.0 means the client is underestimating his hypnotic depth (based on his hypnoidal state score). At this point in time I do not know how useful this score may be. Typically visualizers underestimate their hypnotic depth (in comparison to their therapeutic response, in my opinion) vis-à-vis fantasy highs. If the ratio is less than 1.0, check the hypnotic typology profile to determine the exact nature of the response. Letting the client know that they are a visualizer, a type who typically underestimates their hypnotic depth, may help allay the client's disappointment in their perception that they did not undergo an "alteration in state of consciousness."

The Imagery Vividness Difference Score (IVDS) represents the pre-hypnotic visual imagery vividness score (from the pre-assessment) minus the hypnotic dream imagery vividness score (during the PCI-HAP) . A negative value means the client had more vivid imagery before hypnotism (during the pre-assessment); a positive value means that imagery vividness increased from baseline. Because the stimulus sets for these two variable are different (one concerns relaxing in a hot tub, and the second, the hypnotic dream of being on vacation), these values are not completely comparable. Someone who has a hot tub in their back yard will probably have more vivid imagery when imaging this, as opposed to the hypnotic dream. (The kinesthetic imagery vividness score is not included in the difference score computation. A high score for kinesthetic imagery, and low scores for the other two variables suggests accenting kinesthetic, as opposed to, visual imagery, in any subsequent hypnotic inductions.)

Classic Suggestion Effect Total Score (CSETS): This is the sum of the "yes/no" eye catalepsy item (6 = did not open eyes; 0 = opened eyes) plus the 7-point eye catalepsy item (a score of "7": "impossible to open" = 6, a score of "1": "easy to open" = 0), plus 2 times 6 minus the PCI volitional control item, all divided by 2. A score of 12 means total loss of both behavioral and phenomenological control; a score of 0 means no loss of control whatsoever. Many individuals feel that a loss of control is important for a person to be "hypnotized," i.e., Weitzenhoffer's (1974) classic suggestion effect. However, there appears to be little relationship ($r = .12$, $p > .05$) between behavioral loss of control, as measured by the eye catalepsy item, and phenomenological loss of control, as measured by the PCI volitional control

item (Pekala & Maurer, 2009). Depending whether there is or is not loss of behavioral or phenomenological control, the clinician should use this information in bettering tailoring suggestions to the client's phenomenological world.

Wakefulness Total Score (WTS): This score gives the clinician an idea about how awake the client may have been, and is the sum of the finger raising item of the post-assessment (1= raised finger; 0=did not raise finger), and the sleep item of the post-assessment ("did not fall asleep" = 1; "yes, fell asleep" = 0). A WTS score of "2' suggests that the client was awake (behaviorally and phenomenologically), a score "0" strongly suggests that the client was unresponsive (and possibly asleep) and all PCI-HAP testing results are SUSPECT! A behavioral score of "0," by itself, may also mean that the client was unresponsive/asleep. It should be evaluated in reference to the phenomenological score, and the client should be queried as to what they felt happened when asked to raise their finger.

Directed/Undirected Imagery Vividness Ratio (IVR): This score is a ratio between the Hypnotic Dream Imagery Vividness Item and the PCI Imagery Vividness Item raw score (times 1.67). A score of greater than 1.0 means that the imagery of the hypnotic dream was more vivid than the imagery during the eyes closed sitting quietly period. A score of less than 1.0 means that the hypnotic dream imagery vividness was less vivid than any imagery experienced during the eyes closed sitting quietly period. It is currently unknown if some clients may generate more vivid imagery when therapist directed, as opposed to when the client does this on their own spontaneously. I believe this appears to be a variable needing further research.

Positive Practice Score (PPS): A score of greater than 1.0 may mean that using self-hypnosis will be self-rewarding, that is, the person reports positive (nonsexual) affect when using hypnotism (the higher the number, the more rewarding: highest possible score = 9). This score is the sum of: 2 times the raw score for the joy item plus the love item raw score minus 3 times the raw score of the sexual excitement item, all divided by 2. If the sexual excitement raw score item is greater than 1.0 or the joy raw score is less than 2.0, then the PPS is 0. High scores mean that the client during the PCI-HAP reported what I feel is significant positive (nonsexual) affect; positive affect that may make self-hypnosis self-rewarding to the client. At this point I have no empirical data that this is indeed the case. However, anecdotally, it seems that clients who obtain higher scores for this variable are more able to generate positive feelings associated with the hypnotic experience, especially when practicing on their own.

Page 5: Definitions

This page lists for the clinician the various supplemental scores obtained with the PCI-HAP. No "hard" research data is yet available on these variables. However, because I felt that the information obtained from these variables might be useful, they have been computed and listed on the middle and bottom of page 4 of the EXCEL printout. They have been reviewed in the pages preceding this paragraph, and will not be further discussed. (I usually DO NOT give my private practice client this page, but rather the previous 4 pages of the EXCEL printout, unless they specifically ask for it, or are really interested in the details as to their hypnotic responsivity.)

After the PCI-HAP Review

Where do you go from here? After reviewing the PCI-HAP, I, collaboratively with the client, will make a decision about whether to use hypnotism. If we decide to use hypnotism, I will usually do a hypnotic deepening routine, a hypnotic protocol implementation, and then combine the results from the PCI-HAP, the deepening routine, and the protocol implementation, to cut the

client a CD for an individualized self-hypnosis protocol addressed to the client's individual symptom or concern, while trying to utilize those particular phenomenological processes activated during the PCI-HAP and the subsequent hypnotic deepening.

A hypnotic deepening involves a second round of hypnosis, usually a body scan, mind calm, and subsequent deepening and additional phenomenological assessment.

With the hypnotic deepening I usually begin with body scan and mind calm (counting from “10” to “1”). I will then try to deepen the client's level of trance (using the srHD score) by adding additional counts (I usually use counts of “15” or “10” to “1”) with a particular scenario. My usual deepening strategies include: going down a hillside towards the beach on a beautiful day; going down a mountain towards a lake in a valley on a beautiful day; going down a elevator; going down an escalator; slow deep breathing into the chair; becoming a cloud (provided the client is not fearful of heights); or additional strategies collaboratively constructed by the client and myself (see Appendix B, page 54, for the form I use to do the hypnotic deepening).

During deepening, I will usually ask the client: “Whenever I say ‘what’s your level,’ let a number between ‘1’ and ‘10’ bubble up into your mind indicating how deeply hypnotized your feel yourself to be. “Let ‘1’ equal your normal, waking state of consciousness; let ‘10’ indicate the most deeply hypnotized you can imagine. “Talking won’t disturb you; if anything, it will allow you to go even more deeply into trance. What's your level?" I will try to do the deepening strategies until I get the client to a "7" or greater (on that "1 to 10" scale) or I run out of time.

Additionally, I usually have a 1 or 2 minute sitting quietly period wherein I stop talking interspersed during the deepening to determine if silence deepens or lessens trance depth level. Sometimes I will also use hypnoprojective assessment, if client is highly hypnotizable and/or highly imagoic, as time permits, and I feel such information may be useful.

During the hypnotic protocol implementation, I collaboratively generate with my client suggestions, affirmations, visualizations, and post-hypnotic suggestions to include in an individualized protocol cut for the client, congruent with the phenomenological processes activated according to the PCI-HAP/deepening results. Additionally, I may use published scripts, such as Cory Hammond’s (1990) book, which is excellent. I may also draw from Gawain’s (1978) fine trade psychology book, “Creative Visualization,” in addition to the client's own personal experiences. But since the above is really another manual, we will stop here.

I hope you find the PCI-HAP a useful instrument for helping you individualize your hypnotic interventions. Hopefully, this manual will enable you more easily do that!

Appendices

Tables

Figures

Appendix A: PCI-HAP EXCEL Program Printout

Phenomenology of Consciousness Inventory - Hypnotic Assessment Protocol ~ EXCEL Scoring Program

Please enter the client's name and test date in the designated areas.

Enter Name-> **Ronald J. Pekala** ***Enter Date:*** **10/5/2009**

In the column labeled "Client Responses", please replace the data entered there with the current client's responses.

If the client gives no response for a particular item, please make sure the item is blank on this worksheet by pressing the delete key when in the cell for that item.

Please type in any response the client wrote on his/her form for the following "Enter free response here"

This program is being constantly revised. From time to time, there may be a bug or problem with the program, for which we are unaware. Please e-mail me @ pekalar@voicenet.com with a statement of the problem and also the EXCEL program (changing the name of the client/patient), so that we can trouble shoot the problem. Thank-you!

This spreadsheet was developed in Microsoft Excel 2003 SP2.

PCI12009.2003L.100509.xls

Last revised: 10.05.09

		Client Responses:
	Pre-Assessment	
1.a	Hypnotized before: Yes: enter Y, No: enter N	n
1.b	Year last hypnotized:	
1.c	Last hypnotized: Hypnotic Depth Score	
2	Pre-Hypnotic estimated Hypnotic Depth Score (eHDS)	7
3	Pre-Hypnotic Visual Imagery Vividness Score	4
4	Pre-Hypnotic Kinesthetic Imagery Vividness Score	4
5	Pre-Hypnotic Therapeutic Expectancy Score (pre-TES)	7
	Post-Assessment	
1	Imagoic Suggestibility Score:	7
1. Free response:	*Enter free response here*	
2	Awake behavior item: Raised finger: Yes: enter Y, No: enter N	y
3	Eye catalepsy item: Opened eyes: Yes: enter Y, No: enter N	y
3. Free response:	*Enter free response here*	
4	Awake phenomenological item: 1=Yes, fell asleep; 2=Probably fell asleep; 3=Don't believe they fell asleep;4=No, did not fall asleep	3
5. Sitting quietly period free response:	*Enter free response here*	
6. Feelings after hypnosis free response:	*Enter free response here*	
7. Negative effects	Negative effects item: Yes: enter Y, No: enter N	n
7. Free response:	*Enter free response here*	
8	Post-Hypnotic self-reported Hypnotic Depth Score (srHDS)	8
8. Free response:	*Enter free response here*	
9	Post-Hypnotic Therapeutic Expectancy Score (post-TES)	7
9. Free response:	*Enter free response here*	
10	Eye catalepsy item: 7-point scale: 1=Immediate and easy, 2=With a little effort, 3=Somewhat difficult, 4=Barely able, 5=Did not - but could have, 6=Not able - difficult trying, 7=Impossible - could not	4

Phenomenology of Consciousness Inventory (PCI, Form 1)

Client Name: Ronald J. Pekala **Date:** 10/5/2009

Instructions

In the column labeled "Circled" please replace the numbers typed there with the current client's PCI item scores.

All other cells are "protected", and you cannot edit them.

All scores will be computed automatically...

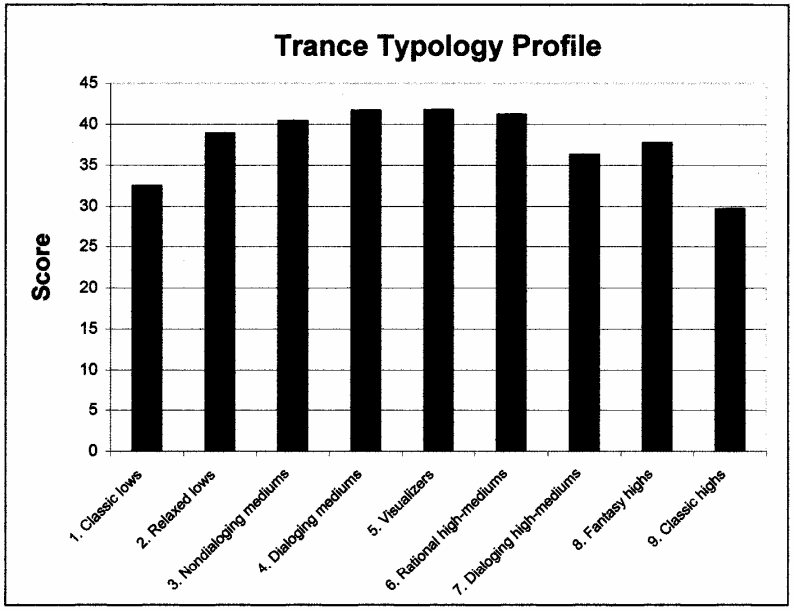
Results will be graphed automatically too.

Item	Circled:	Score	Dimension	Intensity	Label	Percentiles
I01	4	4	D01	1.00	Joy	45.00
I02	1	5	D02	0.00	Sexual Excitement	59.00
I03	3	3	D03	3.00	Love	57.00
I04	2	4	D04	0.00	Anger	68.00
I05	6	0	D05	0.00	Sadness	59.00
I06	5	1	D06	0.00	Fear	61.00
I07	6	0	D07	4.00	Body image	75.00
I08	2	4	D08	4.00	Time sense	66.00
I09	5	1	D09	1.67	Perception	45.00
I10	5	5	D10	2.50	Meaning	77.00
I11	4	4	D11	4.00	Imagery amount	75.00
I12	2	4	D12	4.00	Imagery vividness	74.00
I13	4	4	D13	3.67	Direction of attention	44.00
I14	0	0	D14	4.50	Absorption	94.00
I15	2	4	D15	3.33	Self-awareness	63.00
I16	6	0	D16	3.00	Altered state	31.00
I17	3	3	D17	1.50	Internal dialogue	53.00
I18	2	4	D18	4.67	Rationality	77.00
I19	5	1	D19	2.67	Volitional control	60.00
I20	2	2	D20	4.67	Memory	67.00
I21	4	4	D21	1.00	Arousal	58.00
I22	5	5	D22	1.33	Positive affect	36.00
I23	5	1	D23	0.00	Negative affect	40.00
I24	2	4	D24	3.00	Altered experience	72.00
I25	2	4	D25	4.00	Imagery	74.00
I26	1	5	D26	4.00	Attention	50.00
I27	3	3				
I28	4	4				
I29	5	1				
I30	2	4				
I31	0	0				
I32	1	1				
I33	6	0				
I34	1	5				
I35	0	0				
I36	5	5				
I37	1	1				
I38	2	4				
I39	1	1				
I40	5	1				
I41	1	1				
I42	0	0				
I43	4	4				
I44	4	4				
I45	2	2				
I46	1	1				
I47	4	4				
I48	4	4				
I49	2	4				
I50	3	3				
I51	3	3				
I52	3	3				
I53	4	4				

Item Numbers:

Joy: 9*, 46
Sexual Excitement: 5*, 35
Love: 20, 49*
Anger: 14, 33*
Sadness: 7*, 31
Fear: 16*, 42
Body image: 11, 26*, 51
Time sense: 15*, 30*, 43
Perception: 17*, 29*, 39
Meaning: 4*, 23*, 32, 47
Imagery amount: 12*, 44
Imagery vividness: 18*, 48
Direction of attention: 8*, 28, 52*
Absorption: 1, 34*
Self-awareness: 13, 27*, 50*
Altered state: 21, 40*, 53
Internal dialogue: 6*, 45
Rationality: 2*, 24*, 36
Volitional control: 3*, 25*, 41
Memory: 10, 22, 38*
Arousal: 19* 37

An asterisk (*) denotes items which must be reversed before intensity scores are computed.



HSS = 6.19 Hypnoidal State Score

Trance Typology Profile

Type(s) = 5 - 4

C1	32.53	1. Classic lows
C2	38.95	2. Relaxed lows
C3	40.44	3. Nondialoging mediums
C4	41.73	4. Dialoging mediums
C5	41.81	5. Visualizers
C6	41.23	6. Rational high-mediums
C7	36.34	7. Dialoging high-mediums
C8	37.77	8. Fantasy highs
C9	29.74	9. Classic highs

Reliability	Difference	Items
R1	0	I05 and I35
R2	0	I08 and I28
R3	0	I12 and I44
R4	3	I21 and I40
R5	1	I06 and I45
Reliability Index (RI) Score	**0.80**	

Hypnoidal State Scores typically range between 1 and 9:

1.00 - 3.00	**Non-hypnoidal state**
3.01 - 5.00	**Mild hypnoidal state**
5.01 - 7.00	**Moderate hypnoidal state**
7.01 - 9.00+	**High hypnoidal state**

R I Score = 0.80

RI scores of 2.00 or less are considered reliable
RI scores between 2.01 and 2.29 are marginally reliable
RI scores of 2.30 or greater are unreliable

[For interpretation when using the PCI-HAP, please see the following: Pekala, R. J. & Kumar, V. K. (2000). Operationalizing "Trance:" I: Rationale and Research Using a Psychophenomenological Approach. American Journal of Clinical Hypnosis, 43, 107-135; and Pekala, R. J. (2002). Operationalizing Trance II: Clinical Application Using a Psychophenomenological Approach. American Journal of Clinical Hypnosis, 44, 241-255; & Pekala, R. J. (2009). Therapist Manual: Interpretation of the Phenomenology of Consciousness Inventory: Hypnotic Assessment Procedure (PCI-HAP)]

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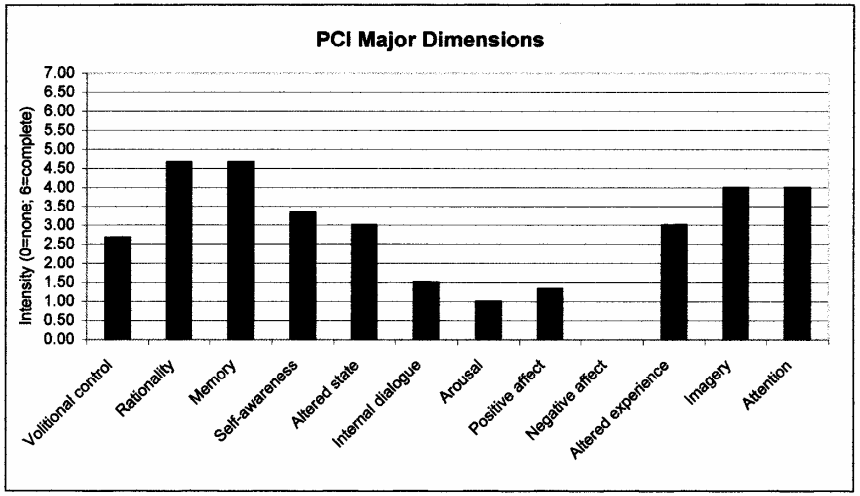
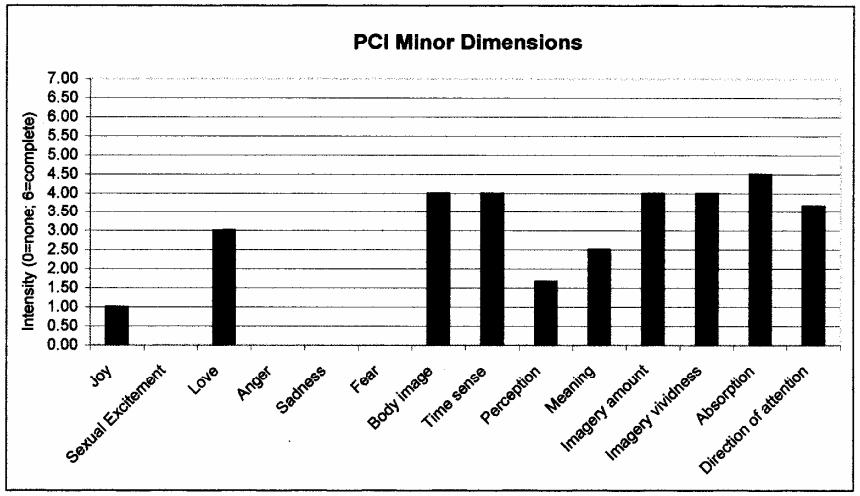
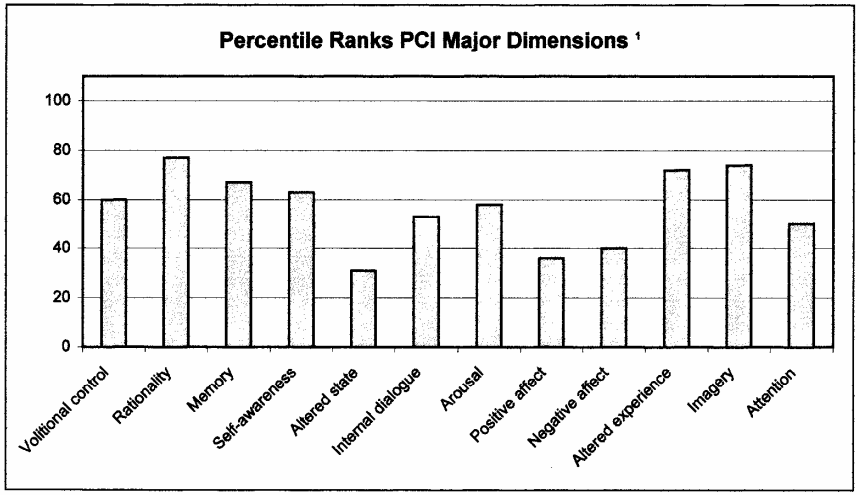
This spreadsheet was developed in Microsoft Excel 2003 SP2. PCI12009.2003L.100509.xls Last revised: 10.05.09

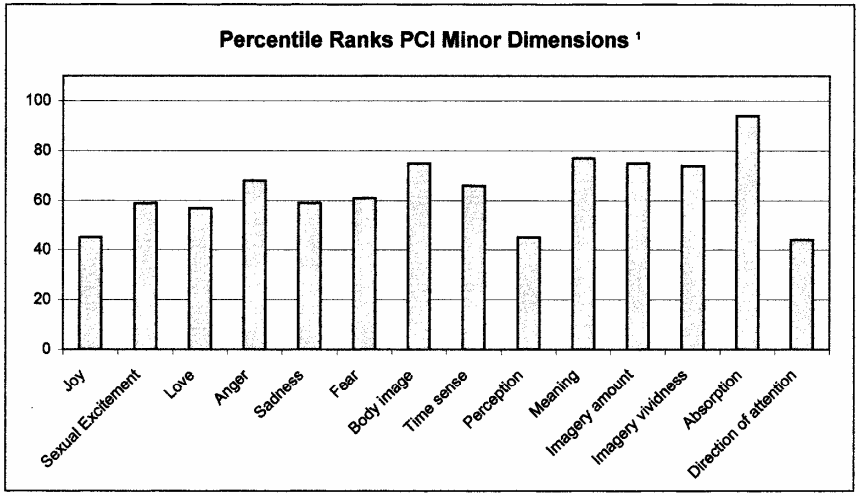
Phenomenology of Consciousness Inventory (PCI, Form 1) (Sub) Dimension Scores

Name: Ronald J. Pekala **Date: 10/5/2009**









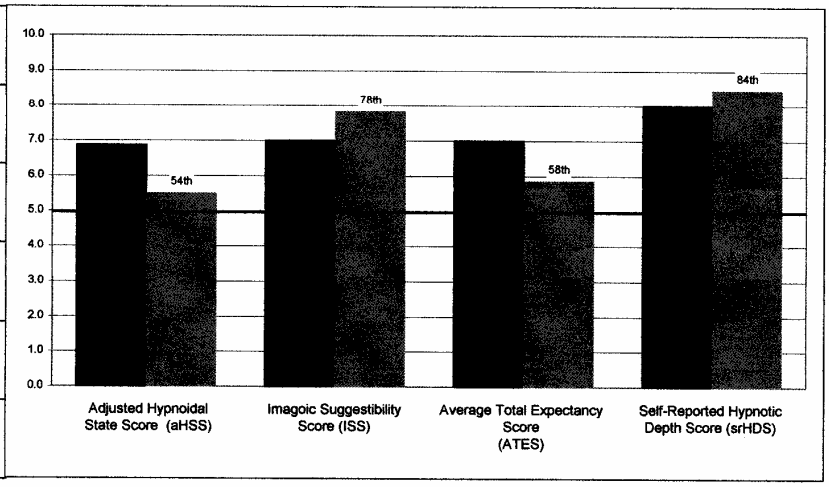
[1] These percentile scores are based on the PCI given in reference to the Harvard (see Pekala, 1991b, pp. 376-379). Unpublished data from Spencer, Kumar, Pekala, & Conte (2000) comparing the PCI (sub)dimension scores between the Harvard and the PCI-HAP suggest nonsignificant differences between both assessments for all subdimensions except imagery amount, imagery vividness, and love. Hence, use of the percentile scores for the graphs generated by EXCEL for all PCI subdimensions (and associated major dimensions) except the above can be assumed to be reasonably correct, since the PCI scores for these (sub)dimensions were not significantly different from one another. The percentile scores for imagery amount, imagery vividness, and love (and their associated major dimensions) have been statistically corrected to control for this overinflation by comparing the data bases of Forbes and Pekala (1993) and Pekala, et. al (2004), and statistically reducing the overinflation corresponding to the differences in the means between these variables.

This spreadsheet was developed□ in Microsoft Excel 2003 SP2. PCI12009.2003L.100509.xls Last revised: 10.05.09

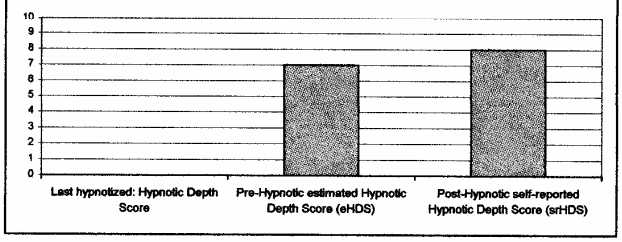
Phenomenology of Consciousness Inventory (PCI, Form 1) Summary

Name: Ronald J. Pekala **Date:** 10/5/2009

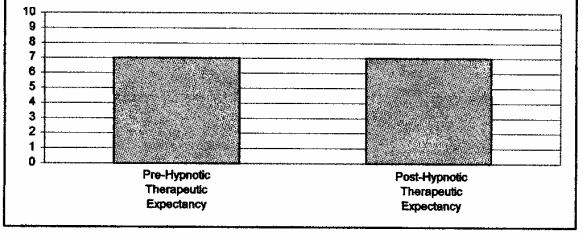
Hypnoidal State Score (HSS)	6.19	%ile Rank	
Adjusted Hypnoidal State Score (aHSS)	6.87	54.90	1
Imagoic Suggestibility Score (ISS)	7.00	78.20	2
Average Total Expectancy Score (ATES)	7.00	58.54	3
Self-reported Hypnotic Depth Score (srHDS)	8.00	84.50	2
Hypnotic Responsivity Index (HRI)	7.22	69.03	



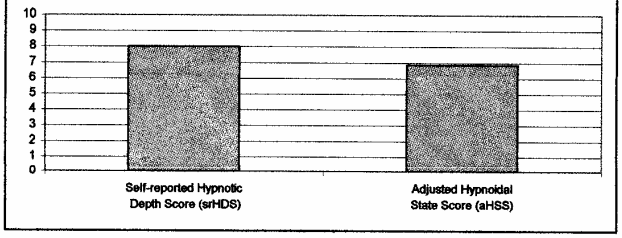
Pre-Post Hypnotic Depth Difference Score (HDDS) =	1.00



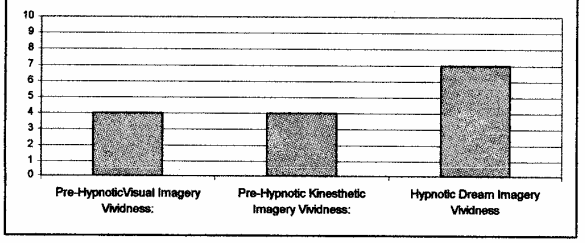
Pre-Post Therapeutic Expectancy Difference Score (TEDS) =	0.00



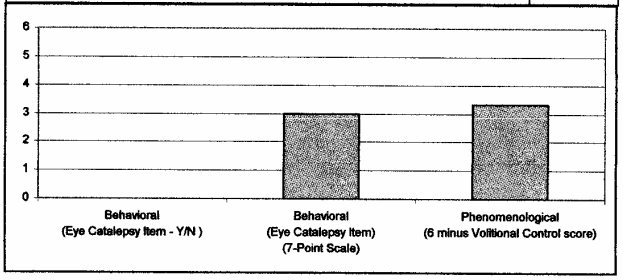
Hypnotic Depth Score/Adjusted Hypnoidal State Discrepancy (aHSS) Ratio =	1.16



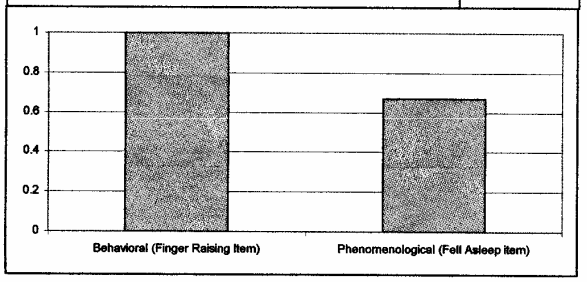
Imagery Vividness Difference Score (IVDS) =	3.00



Classic Suggestion Effect Total Score (CSETS) =	4.83



Wakefulness Total Score (WTS)	1.67



Directed/Undirected Imagery Vividness Ratio (IVR) =	1.05

Positive Practice Score (PPS) =	0.00

*1 Percentiles are based on an *n* of 184 (nursing students); from Pekala & Forbes, 1997, *American Journal of Clincial Hypnosis*

*2 Percentiles are based on an *n* of 363 (drug and alcohol substance abusers); research in progress

*3 Percentiles are based on an n of 123 (drug and alcohol substance abusers); research in progress

This spreadsheet was developed in Microsoft Excel 2003 SP2. PCI12009.2003L.100509.xls Last revised: 10.05.09

Phenomenology of Consciousness Inventory (PCI, Form 1) Definitions:

Hypnoidal State Score (HSS): Overall measure of "trance depth"; hypnoidal depth score; predicted Harvard Group Scale (pHGS) score based on regression equation (Pekala & Kumar, 1987); correlates about .60 with Harvard Scale score across several studies. Score ranges: 1.00-3.00: Non-hypnoidal state; 3.01-5.00: Mild hypnoidal state; 5.01-7.00: Moderate hypnoidal state; 7.01 - 9.00+: High hypnoidal state.

Adjusted Hypnoidal State Score (aHSS): The hypnoidal State Score (HSS) has been multiplied by 1.11 to put it on the same 1 to 10 scale as the other measures depicted on the graph to the right of the scores.

Imagoic Suggestibility Score (ISS): The vividness of the client's visual imagery during the hypnotic dream.

Average Total Expectancy Score (ATES): This is the client's averaged pre- and post-hypnotic expectancy score. It is the average of the two pre-hypnotic expectancy scores: the pre-hypnotic estimated hypnotic depth score and the pre-hypnotic therapeutic expectancy score plus the post-hypnotic therapeutic expectancy score divided by 2. It represents the average expectancy score across pre- and post-hypnotic conditions.

Post-Hypnotic Self-Reported Hypnotic Depth Score (srHDS): How deeply hypnotized the client felt themselves to be.

Hypnotic Responsivity Index (HRI): This is the mean score and percentile score averaged across the four variables: adjusted hypnoidal state score, imagoic suggestibility score, average total expectancy score, and the post-hypnotic self-reported hypnotic depth score.

Pre-Post Hypnotic Depth Difference Score (HDDS): This is the difference between how hypnotizable the client thought they were going to be before hypnosis, versus how hypnotized they felt they became during the PCI-HAP. A negative score indicates a negative response expectancy, and one should try to reverse this during the subsequent hypnotic deepening procedure.

Pre-Post Therapeutic Expectancy Difference Score (TEDS): This is the difference between how helpful the client thought hypnosis would be before hypnosis, versus how helpful they feel it is going to be after hypnosis. A negative expectancy score indicates a negative therapeutic expectancy, and should be discussed.

Hypnotic Depth/Adjusted Hypnoidal State Discrepancy Ratio (HDDR): This is the ratio between the post-hypnosis self-reported Hypnotic Depth Score and the adjusted Hypnoidal State Score (this score is multiplied by 1.11 since it runs from 1 to 9; the srHD score runs from 1 to 10). A ratio of greater than 1.0 indicates that the client is overestimating his hypnotic depth (based on his hypnoidal state score), while a ratio of less than 1.0 means the client is underestimating his hypnotic depth (based on his hypnoidal state score).

Imagery Vividness Difference Score (IVDS): This is the pre-hypnotic visual imagery vividness scores minus the hypnotic dream imagery vividness score. A negative value means the client had more vivid imagery before hypnosis; a positive value means that imagery vividness increased from baseline.

Classic Suggestion Effect Total Score (CSETS): This is the sum of the "yes/no" eye catalepsy item (6 = did not open eyes; 0 = opened eyes) plus the 7-point eye catalepsy item (a score of "7": "impossible to open" = 6, a score of "1": "easy to open" = 0), plus 2 times 6 minus the PCI volitional control item, all divided by 2. A score of 12 means total loss of both behavioral and phenomenological control; a score of 0 means no loss of control whatsoever.

Wakefulness Total Score (WTS): Wakefulness Total Score (WTS): This score gives the clinician an idea about how awake the client may have been, and runs from 0 to 2. It is the sum of the finger raising item of the post-assessment (scored: raised finger = 1; did not raise finger = 0), and the sleep item of the post-assessment (scored: "did not fall asleep" = 1; "don't believe they fell asleep" = .67; "probably fell asleep" = .33; "yes, fell asleep" = 0). A WTS score of "2" suggests that the client was awake (behaviorally and phenomenologically); a score "0" strongly suggests that the client was asleep and all PCI-HAP testing results are SUSPECT! A behavioral score of "0" may also mean that the client was asleep; it should be evaluated in reference to the phenomenological score.

Directed/Undirected Imagery Vividness Ratio (IVR): This score is a ratio between the Hypnotic Dream Imagery Vividness Item and the PCI Imagery Vividness Item raw score (times 1.67). A score of greater than 1.0 means that the imagery of the hypnotic dream was more vivid than the imagery during the eyes closed sitting quietly period. A score of less than 1.0 means that the hypnotic dream imagery vividness was less vivid than any imagery experienced during the eyes closed sitting quietly period.

Positive Practice Score (PPS): A score of greater than 1.0 typically means that using self-hypnosis will be self-rewarding, that is the person reports positive (nonsexual) affect when using hypnosis (the higher the number, the more rewarding: highest possible score = 9). This score is the sum of: 2 times the raw score for the joy item plus the love item raw score minus 3 times the raw score of the sexual excitement item, all divided by 2. If the sexual excitement raw score item is greater than 1.0 or the joy raw score is less than 2.0, then the PPS is 0.

[This spreadsheet is partially based on research obtained with grants received from the Veterans Administration Stars and Stripes (VISN4) Healthcare Network. All research grants were approved by the IRB and R&D committees of the hospital where the research was conducted. The contents of this protocol do not represent the views of the Department of Veterans Affairs nor the United States Government.]

Table 1.
Predicting Self-Reported Hypnotic Depth (srHD) from the PCI-HAP Variables Using the Total Combined Expectancy Variable

Subscale	R	R^2	Unstandardized Coefficient	Standardized Coefficient	*F* Value[1]	*p* Value[2]
Imagoic Suggestibility (Imagery Vividness Dream Item)	0.677	0.458	0.398	0.45	52.14	0.000
Total Combined Expectancy	0.782	0.611	0.486	0.35	29.64	0.000
Eye Catalepsy Item	0.796	0.633	0.781	0.14	5.73	0.018
Hypnoidal State (pHGS Score)	0.803	0.645	0.234	0.13	3.98	0.048
Constant			-2.364			

[1]*F* and *p* are initial values for independent variables left in the regression equation.
[2]*n* = 123

[From: Self-Reported Hypnotic Depth as a Function of Suggestibility, Expectancy, and Trance State Effects: II. Assessment via the PCI-HAP. (2009c). Manuscript submitted for publication.]

Table 2.
Percentages of the Nine Hypnotic Types Across Several Studies: Statistically Corrected for Inflation of the Visualizers[1]

Hypnotic Type	Trance 2000 Paper Table 5 (page 125)	Pekala & Maurer, 2008
Classic Lows	7.7%	9.4%
Relaxed Lows	13.1%	10.6%
Nondialoging Mediums	7.4%	16.7%
Dialoging Mediums	22.3%	26.1%
Visualizers	10.1%	12.2%
Rational High-Mediums	6.8%	6.7%
Dialoging High-Mediums	10.3%	9.4%
Fantasy Highs	9.4%	3.9%
Classic Highs	12.8%	5.0%
n	852	180

[1]PCI intensity scores for: love (68.8)%, imagery amount (72.6%), imagery vividness (74.9%), positive affect (61.5%) and imagery (73.8%) were statistically reduced by the amount shown in parentheses to correct for inflation of these scores due to the PCI-HAP having a hypnotic dream (which the Harvard did not have) reducing the intensity scores for these dimensions by the amount shown in parenthesis, which represent the results of Forbes & Pekala, 1997 (research data with the Harvard with nursing students) divided by the results of Pekala and Maurer, 2008 (research data for the PCI-HAP with veterans) for the means of these particular (sub)dimensions. The column of Pekala and Maurer, 2008, represents the corrected value (using the PCI-HAP with a different sample - veterans); included are the results of Pekala & Kumar, 2000, for comparison purposes. Prior to this correction, the EXCEL program generated visualizers at least 25% of the time.

Table 3.
Means and Standard Deviations for the PCI-HAP Variables

Variables	Mean[1]	SD
1. Self-Reported Hypnotic Depth (srHD)	5.19	2.71
2. Hypnoidal State (pHGS Score)	5.42	1.46
3. Imagoic Suggestibility (Imagery Vividness Dream Item)	4.81	3.08
4. Finger Response Item	1.34	0.53
5. Eye Catalepsy Item	1.52	0.50
6. Fell Asleep Item	2.84	1.06
7. Negative Effects	1.98	0.16
8. Pre-hypnotic Estimated Hypnotic Depth	5.93	2.60
9. Pre-Hypnotic Visual Imagery Vividness	6.06	2.81
10. Pre-Hypnotic Kinesthetic Imagery Vividness	5.54	2.84
11. Pre-Hypnotic Expected Therapeutic Efficacy	6.94	2.37
12. Pre-Hypnotic Combined Expectancy	6.44	2.08
13. Post-Hypnotic Therapeutic Efficacy	6.67	2.59
14. Total Combined Expectancy	6.55	1.94

[1] $n = 123$

[From: Self-Reported Hypnotic Depth as a Function of Suggestibility, Expectancy, and Trance State Effects: II. Assessment via the PCI-HAP. (2009c). Manuscript submitted for publication.]

Table 4
Pearson Correlation Matrix for the PCI-HAP Variables[1]

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Self-Reported Hypnotic Depth (srHD)	1.00												
2. Hypnoidal State (pHGS) Score	.48[2] (.57[3])	1.00											
3. Imagoic Suggestibility (Imagery Vividness Dream Item)	.68 (.72)	.36 (.45)	1.00										
4. Finger Response Item	.06 (.20)	-.07 (.08)	.14 (.19)	1.00									
5. Eye Catalepsy Item	.45 (.15)	.30 (.30)	.34 (.08)	-.25 (-.26)	1.00								
6. Fell Asleep Item	.12 (.08)	.35 (.27)	.05 (.06)	-.25 (-.32)	.19 (.18)	1.00							
7. Negative Effects	-.13	-.04	-.03	.00	.04	.02	1.00						
8. Pre-Hypnotic Estimated Hypnotic Depth	.43	.19	.34	.18	.21	-.01	-.23	1.00					
9. Pre-Hypnotic Visual Imagery Vividness	.34	.20	.28	.15	.25	.05	-.09	.42	1.00				
10. Pre-Hypnotic Kinesthetic Imagery	.35	.19	.34	.16	.18	.08	-.12	.42	.83	1.00			

Vividness													
11. Pre-Hypnotic Expected Therapeutic Efficacy	.42	.35	.22	.14	.21	.07	-.18	.41	.46	.48	1.00		
12. Pre-Hypnotic Combined Expectancy	.51	.32	.34	.19	.25	.04	-.25	.86	.52	.53	.82	1.00	
13.Post-Hypnotic Expected Therapeutic Efficacy	.52	.40	.30	.11	.27	.00	-.13	.22	.31	.27	.43	.38	1.00
14. Total Combined Expectancy	.62	.43	.38	.18	.32	.02	-.21	.60	.49	.47	.72	.79	.87

[1]*n* = 123

[2] *r* > .18 (p < .05); *r* >.23 (p < .01); and, *r* > .29 (p < .001)

[3]Correlations in parentheses represent correlations from an earlier study that were reported in Pekala et al., 2006.

[From: Self-Reported Hypnotic Depth as a Function of Suggestibility, Expectancy, and Trance State Effects: II. Assessment via the PCI-HAP. (2009c). Manuscript submitted for publication.]

Table 5.
Hypnoidal State (pHGS score) Regression Equation

PCI (Sub)Dimension	x	Unstandardized Regression Coefficient	Relative Percentage
Altered Experience	x	+.35	17%
Altered State	x	+.31	15%
Volitional Control	x	-.28	13%
Self-Awareness	x	-.27	13%
Rationality	x	+.23	11%
Absorption	x	+.19	9%
Memory	x	-.14	7%
Altered Time Sense	x	+.13	6%
Internal Dialogue	x	-.11	5%
Altered Body Image	x	-.07	3%
Constant		+4.51	

Note: Percentages indicate relative magnitude of the coefficient. Each PCI (sub)dimension is rated on a "0" to "6" scale, with "0" indicating "none or little," and "6" indicating "much or complete.

Table 6

pHGS Percentile Scores

pHGS Score	Percentile	pHGS Score	Percentile	pHGS Score	Percentile	pHGS Score	Percentile
1.84	0.5	**4.96**	26.1	**6.23**	55.4	**7.50**	83.2
1.93	1.1	**4.97**	26.6	**6.24**	56.5	**7.53**	84.2
1.96	1.6	**4.98**	27.2	**6.29**	58.2	**7.55**	84.8
2.27	2.2	**4.99**	27.7	**6.30**	58.7	**7.57**	85.3
2.28	2.7	**5.02**	28.3	**6.31**	59.2	**7.58**	85.9
2.65	3.3	**5.04**	28.8	**6.34**	59.8	**7.60**	87.0
2.67	3.8	**5.06**	29.9	**6.39**	60.3	**7.62**	87.5
2.71	4.3	**5.14**	30.4	**6.46**	60.9	**7.69**	88.0
2.78	4.9	**5.16**	31.0	**6.47**	61.4	**7.70**	88.6
2.83	5.4	**5.23**	31.5	**6.50**	62.0	**7.71**	89.1
2.88	6.0	**5.25**	32.1	**6.51**	62.5	**7.75**	89.7
2.89	6.5	**5.32**	32.6	**6.54**	63.0	**7.84**	90.2
2.94	7.1	**5.35**	33.2	**6.58**	63.6	**7.86**	90.8
3.14	7.6	**5.37**	33.7	**6.66**	64.1	**7.88**	91.3
3.31	8.2	**5.40**	34.2	**6.72**	64.7	**7.90**	91.8
3.35	8.7	**5.44**	34.8	**6.74**	65.2	**7.93**	92.4
3.39	9.2	**5.45**	35.3	**6.77**	66.3	**7.94**	92.9
3.40	9.8	**5.46**	36.4	**6.78**	66.8	**8.05**	93.5
3.44	10.3	**5.48**	37.5	**6.79**	67.4	**8.07**	94.0
3.47	10.9	**5.57**	38.6	**6.81**	67.9	**8.12**	94.6
3.50	12.0	**5.63**	40.2	**6.84**	68.5	**8.22**	95.1
3.55	12.5	**5.68**	40.8	**6.90**	69.0	**8.25**	95.7
3.74	13.0	**5.70**	41.3	**6.99**	69.6	**8.38**	96.2
3.80	13.6	**5.71**	41.8	**7.00**	70.1	**8.39**	96.7
3.83	14.7	**5.74**	42.4	**7.01**	70.7	**8.41**	97.3
3.87	15.8	**5.77**	42.9	**7.04**	71.2	**8.61**	97.8
3.91	16.3	**5.80**	44.0	**7.06**	72.3	**8.94**	98.4
3.93	17.4	**5.82**	44.6	**7.07**	73.9	**9.02**	98.9
4.00	17.9	**5.83**	45.1	**7.09**	74.5	**9.41**	99.5
4.02	18.5	**5.85**	46.2	**7.10**	75.0	**9.44**	100.0
4.13	19.0	**5.86**	46.7	**7.24**	75.5		
4.15	19.6	**5.87**	47.3	**7.26**	76.1		
4.20	20.1	**5.88**	47.8	**7.27**	76.6		
4.22	20.7	**5.94**	48.4	**7.30**	77.2		
4.25	21.2	**5.96**	49.5	**7.31**	77.7		
4.28	21.7	**5.98**	50.0	**7.32**	78.8		
4.29	22.3	**5.99**	50.5	**7.36**	79.3		
4.33	22.8	**6.07**	51.1	**7.38**	79.9		
4.38	23.4	**6.08**	51.6	**7.39**	80.4		
4.69	23.9	**6.09**	52.2	**7.42**	81.0		
4.72	24.5	**6.10**	52.7	**7.47**	81.5		
4.77	25.0	**6.19**	53.8	**7.48**	82.1		
4.81	25.5	**6.21**	54.9	**7.49**	82.6		

[The percentile values are based on the PCI given in reference to a sitting quietly period embedded in the Harvard Group Scale. Use of these values with the PCI-HAP are hence only approximate.]

[pHGSscor.pct.doc on c:\ron\presentations\SCEH2005\workshop\appendices\; on RonP's Dell notebook]

n = 184; RI (reliability index) < 2.00

From: Pekala & Forbes (1997), AJCH.

Figure 1

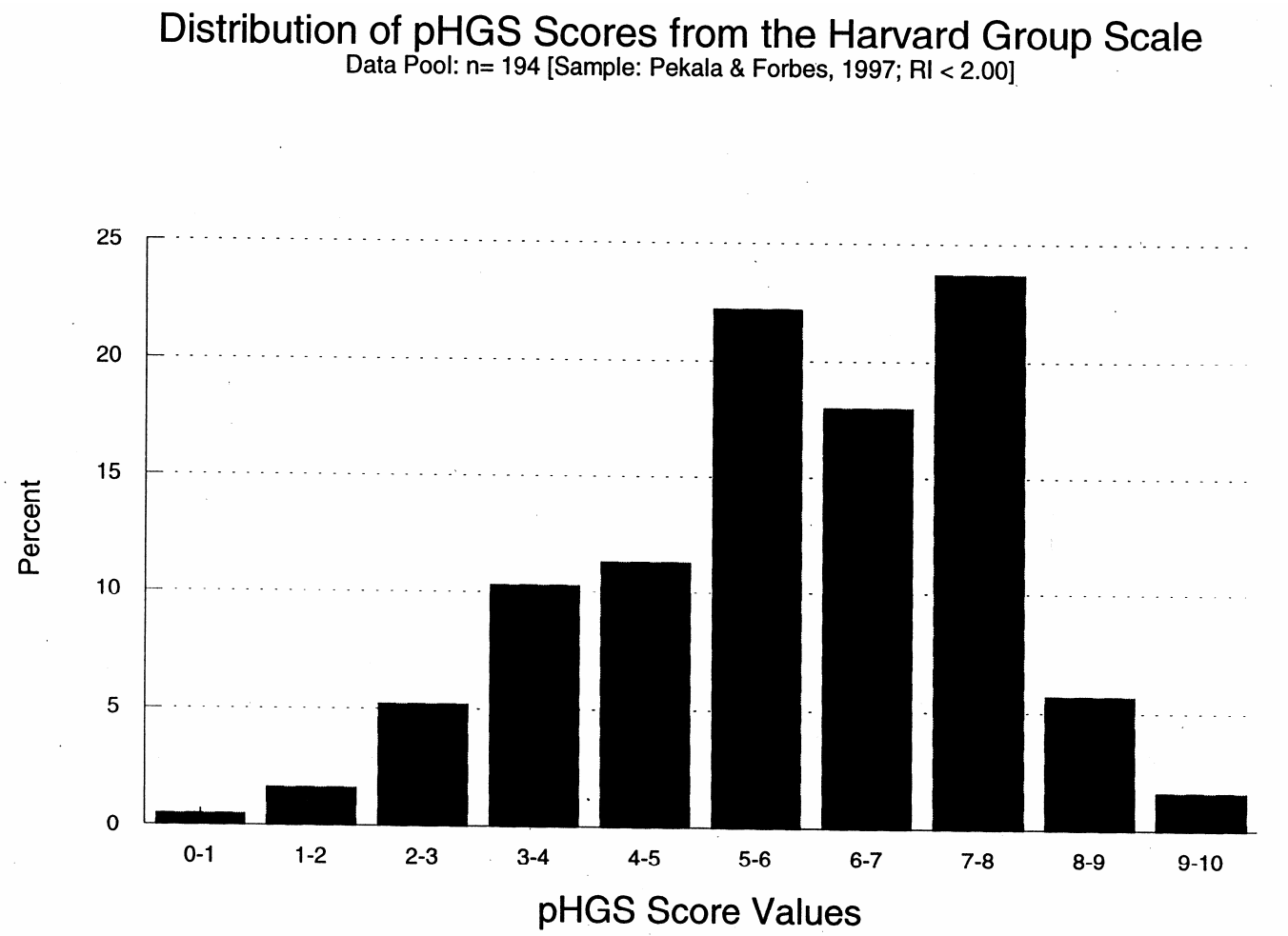


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Figure 2

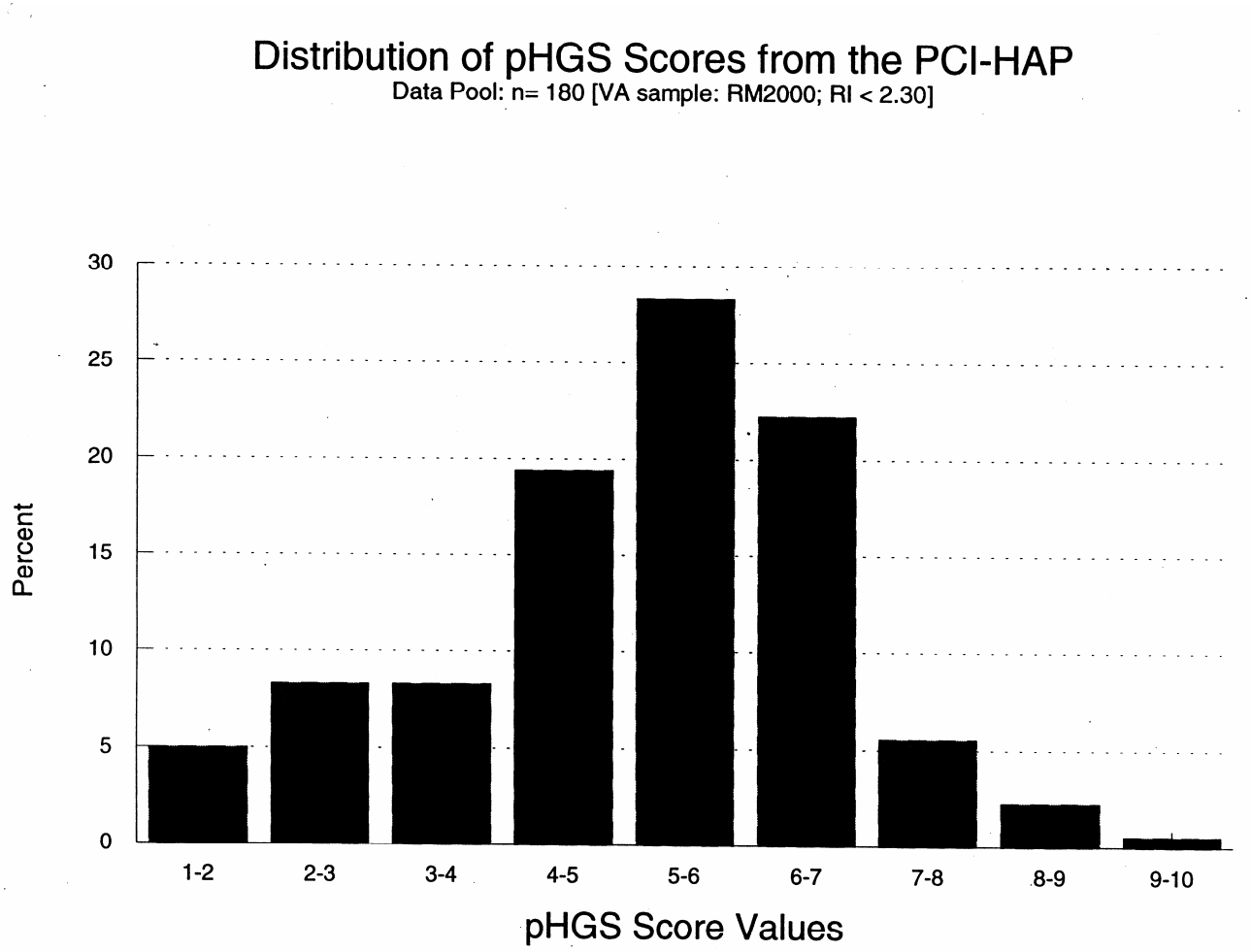

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Table 7

The Nine Hypnotic Types, Average Trance Depth, and Distinguishing Characteristics

Hypnotic Type	Hypnoidal State Score[b]	Distinguishing Characteristics of Each of the Nine Cluster Types[a] (based on intensity levels of PCI major dimensions)
CLASSIC LOWS	2.88	Highest level of arousal (muscular tension); most intact memory, rationality, and self-awareness; most internal dialogue; least drop in volitional control
RELAXED LOWS	3.68	Similar to classic lows except have low muscle tension levels and less internal dialogue
NONDIALOGING MEDIUMS	4.87	Similar to dialoging mediums except for lack of internal dialogue
DIALOGING MEDIUMS	5.01	Similar to nondialoging mediums except for more internal dialogue
VISUALIZERS	6.06	Highest level of visual imagery; highest level of self-awareness and intact memory after classic and relaxed lows
RATIONAL HI-MEDIUMS	6.81	Similar to dialoging high-mediums except for less internal dialogue and more rationality
DIALOGING HI-MEDIUMS	6.86	Second highest level of internal dialogue after classic lows; similar to rational high-mediums except for more internal dialogue and less rationality
FANTASY HIGHS	7.10	Second highest level of imagery after visualizers
CLASSIC HIGHS	7.60	Lowest level of memory, rationality, internal dialogue, imagery, and self-awareness

[a]Based on Pekala & Forbes (1997) in American Journal of Clinical Hypnosis

[b]Hypnoidal State Score: Average level of trance depth: Scores go from approximately 1.0 (not hypnotizable) to 9.0 (highly hypnotizable)

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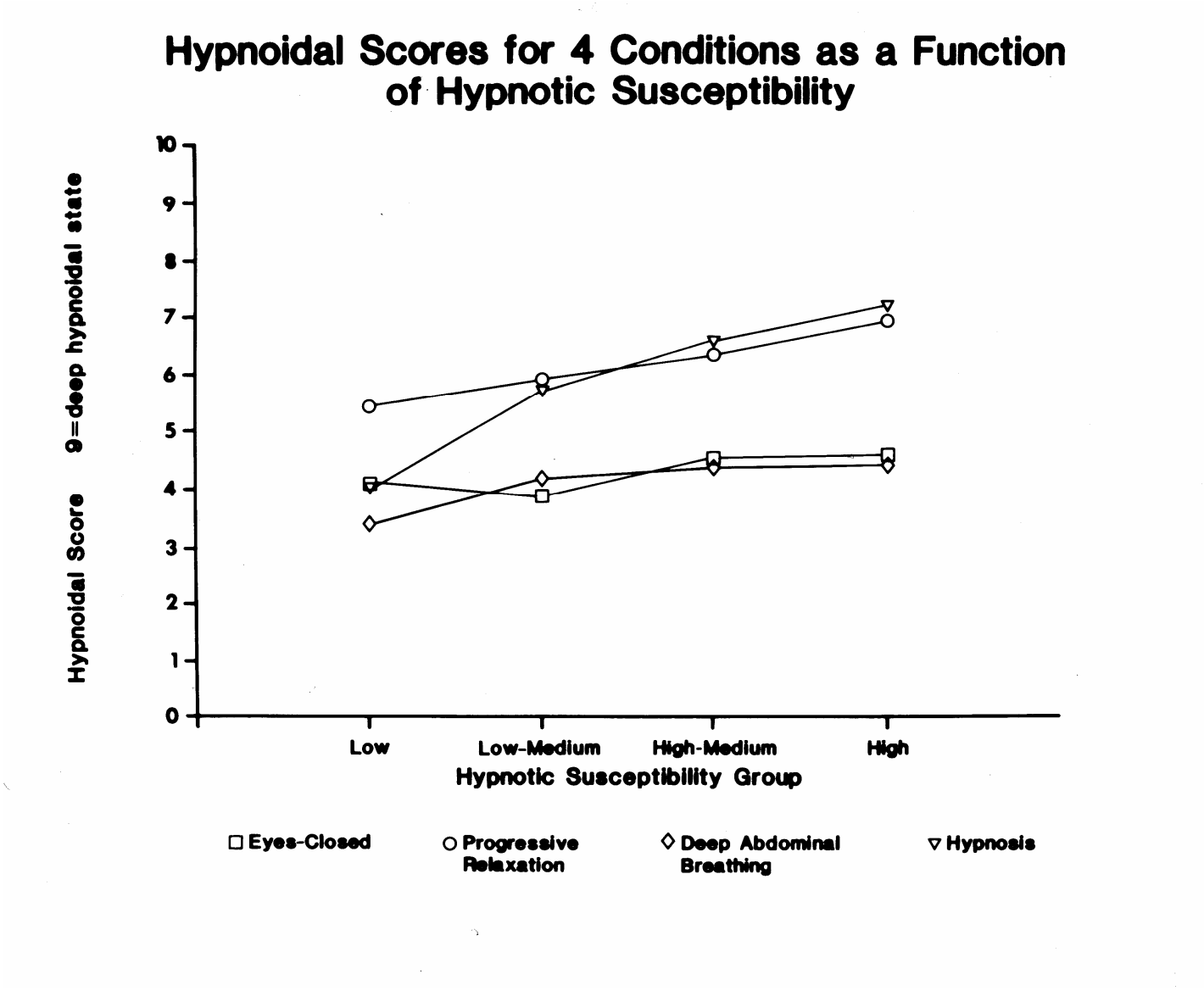
[From: Pekala, R. J., & Kumar, V. K. (2000). Operationalizing "trance:" I: Rationale and research using a psychophenomenological approach. *American Journal of Clinical Hypnosis, 43*, 107-135.]

Figure 3



[From: Pekala, R. J., Forbes, E., & Contriasani, P. (1988/89). Hypnoidal effects associated with several stress management strategies. *Australian Journal of Clinical and Experimental Hypnosis*, *16*, 121-132.]

Table 8

Percentage of Ss per Cluster Type Across Three Different Studies

	Study[a]			
	ASCH '97	AJCEH '96	JASPR '95	AVERAGE
1. CLASSIC LOWS	5.7%	8.6%	8.7%	7.7%
2. RELAXED LOWS	12.4%	14.3%	12.6%	13.1%
3. NONDIALOGING MEDIUMS	9.3%	6.1%	6.8%	7.4%
4. DIALOGING MEDIUMS	12.4%	10.6%	43.8%	22.3%
5. VISUALIZERS	10.8%	9.4%	10.7%	10.1%
6. RATIONAL HIGH-MEDIUMS	12.4%	6.1%	1.9%	6.8%
7. DIALOGING HIGH-MEDIUMS	13.4%	9.8%	7.7%	10.3%
8. FANTASY HIGHS	10.3%	12.2%	5.6%	9.4%
9. CLASSIC HIGHS	13.4%	22.9%	2.2%	12.8%
n =	194	245	413	852

[a]Study: AJCH '97 = Types of hypnotically (un)susceptible individuals as a function of phenomenological experience: Towards a typology of hypnotic types; AJCH '96 = Types of hypnotically (un)susceptible individuals as a function of phenomenological experience: A partial replication; JASPR '95 = Anomalous/paranormal experiences, hypnotic susceptibility, and dissociation

[percent.doc on on c:\ron\presentations\Workshop\Appendices;\RonP's notebook]

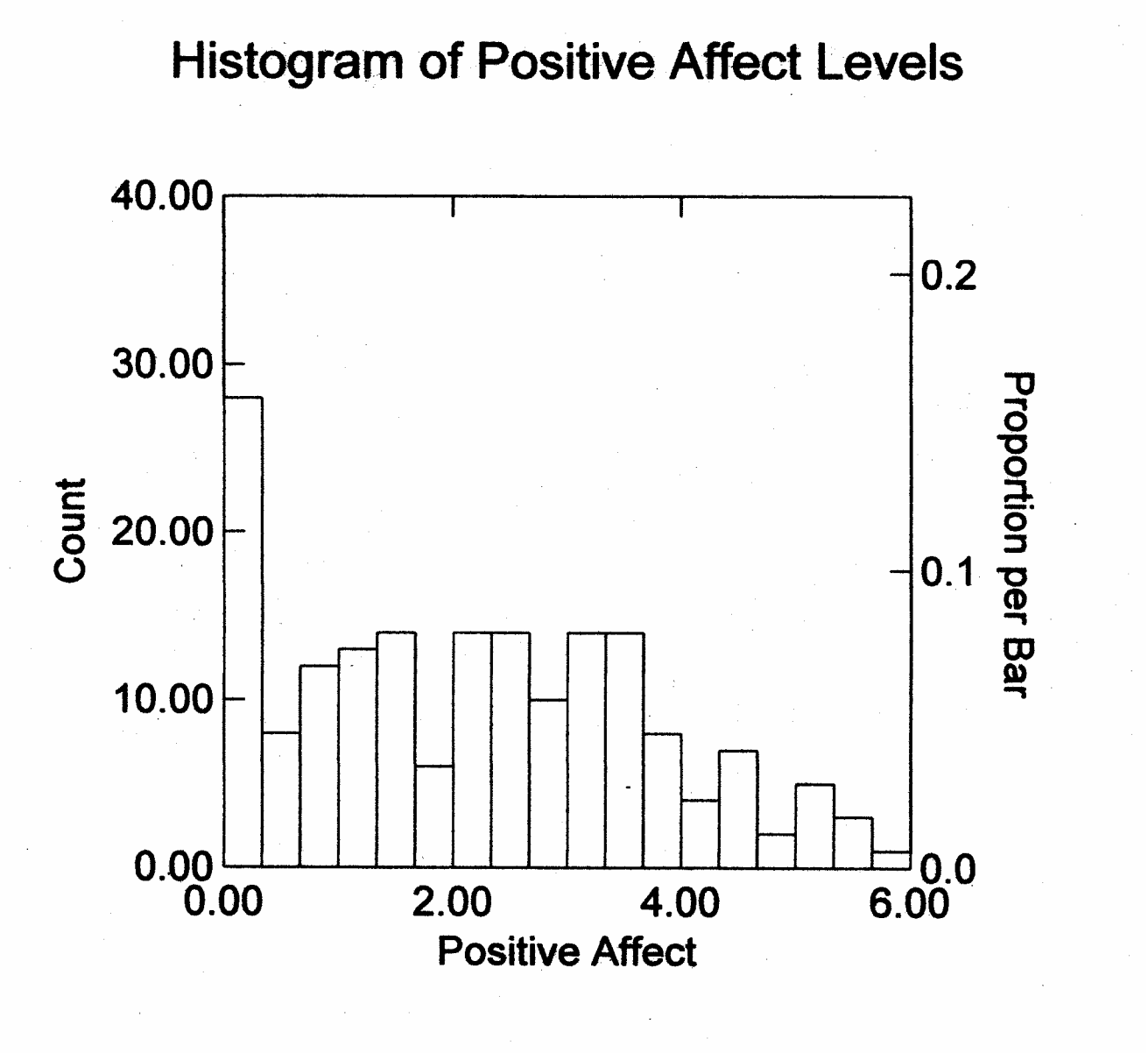
[From: Pekala, R. J., & Kumar, V. K. (2000). Operationalizing "trance:" I: Rationale and research using a psychophenomenological approach. *American Journal of Clinical Hypnosis, 43*, 107-135.]

Table 9. Description of the PCI Dimensions

Positive Affect	Positive affect consists of three subdimensions: joy, sexual excitement, and love. Joy assesses feelings of ecstasy and extreme happiness. Sexual excitement assesses the extent of intense sexual feelings. Love assesses feelings of love and loving-kindness.
Negative Affect	Negative affect consists of three subdimensions: anger, sadness, and fear. Anger assesses feelings of being very angry and upset or enraged. Sadness assesses feelings of being very, very sad or unhappy. Fear assesses feeling very frightened or being scared or afraid.
Altered Experience	Altered experience consists of four subdimensions: altered body image, altered time sense, altered perception, and altered or unusual meaning. Altered body image assesses the extent to which participants feel their bodily feelings expand into the world around them. Altered time sense assesses the extent to which the flow of time changed drastically or whether it seemed to speed up or slow down. Altered perception assesses changes in the perception of the world in terms of color, form, size, shape, or perspective. Unusual meanings assess the extent to which the reports of experiences that might be labeled religious, spiritual, or transcendental, or has feelings of awe, sacredness, or reverence.
Visual Imagery	Visual imagery consists of two subdimensions: amount of imagery and vividness of imagery. Imagery amount assesses the amount of imagery. Vividness of imagery assesses the extent to which the imagery is vivid and three-dimensional or as clear and vivid as objects in the real world.
Attention	Attention consists of two subdimensions: direction of attention and absorption. Direction of attention assesses whether the attention is directed toward an internal subjective experience or toward the environment around the participant. Absorption assesses whether the participant is absorbed in what they are experiencing or whether they are continually being distracted by extraneous impressions.
Self-Awareness	Self-awareness assesses the extent to which the participant is aware of being aware of self or whether the participant looses consciousness of self or is not aware of being aware of self.
Altered State of Awareness	Altered state of awareness assesses whether the participant is in an extraordinarily unusual and nonordinary state of awareness or is in a state of consciousness not any different than usual.
Internal Dialogue	Internal dialogue assesses the extent to which the participant is talking silently to self a great deal or did not engage in any silent talking to self.
Rationality	Rationality assesses whether the participant's thinking is clear and distinct or rational and easy to comprehend or is confused and muddled or nonrational and very hard to comprehend.
Volitional Control	Volitional control assesses the extent to which the participant has complete control over what they are paying attention to or is willfully controlling their experience, versus whether they are being passive and receptive to the experience or having images and thoughts pop into their mind without any control of it.
Memory	Memory assesses the subjective perception that the participant can remember just about everything that they experienced or whether they are not able to remember whatever they experienced.
Arousal	Arousal assesses the extent of muscular tension or the extent to which the muscles of the body are very tense and tight or not tense or tight at all.

[Note: Table composed from Quantifying Consciousness: An Empirical Approach (Pekala, 1991a, pp. 130-132). Taken and modified with permission from: Hageman, J. (2003). The interactive role of hypnotizability and dissociative capacity in the felt and lived experience of spirituality: Implications for health and well-being. PhD Dissertation, San Francisco, CA, p. 119.]

Figure 4



[From: Pekala R. J., Kumar, V. K., Maurer, R., Elliott-Carter, N., & Moon, E., Mullen, K. (2009a). Positive affect, negative affect, and negative effects during a phenomenological hypnotic assessment within a substance abuse population. *International Journal of Clinical and Experimental Hypnosis, 57*, 64-93.]

Table 10

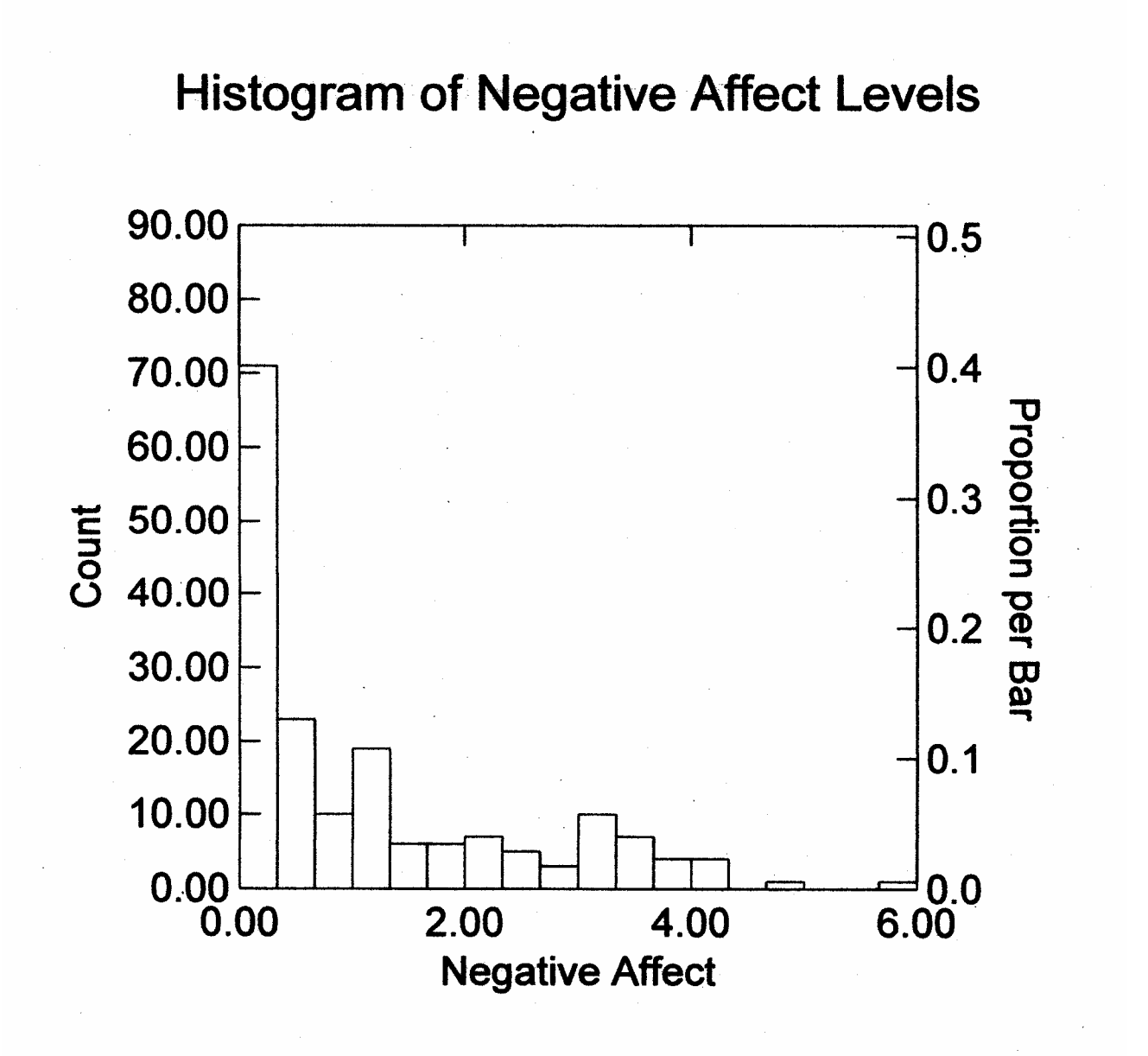
Predicting Positive Affect from the PCI-HAP and Several Additional Variables

Subscale	*R*	R^2	Unstandardized Coefficient[2]	Standardized Coefficient	F Value[1]	p Value
Vividness of Hypnotic Dream (Imagoic Suggestibility)	0.555[2]	0.308	0.203	0.398	18.667	0.000
pHGS score (Hypnoidal State)	0.581	0.338	0.125	0.133	3.402	0.067
Self-reported Hypnotic Depth	0.589	0.347	0.076	0.138	2.231	0.137
Child Abuse Total Score	0.597	0.356	-0.217	-0.099	2.111	0.148`
Constant			0.728			

[1]F and p values refer to final F and p values using only those independent variables left in the regression equation. Variables not left in the regression equation: eye catalepsy score, fantasy proneness score, DES score, fell asleep item, finger response item
[2]Unstandardized and standardized coefficients are from complete regression analysis using only the above variables in the regression equation.
[3]n = 172

[From: Pekala R. J., Kumar, V. K., Maurer, R., Elliott-Carter, N., & Moon, E., Mullen, K. (2009a). Positive affect, negative affect, and negative effects during a phenomenological hypnotic assessment within a substance abuse population. *International Journal of Clinical and Experimental Hypnosis, 57*, 64-93.]

Figure 5



[From: Pekala R. J., Kumar, V. K., Maurer, R., Elliott-Carter, N., & Moon, E., Mullen, K. (2009a). Positive affect, negative affect, and negative effects during a phenomenological hypnotic assessment within a substance abuse population. *International Journal of Clinical and Experimental Hypnosis, 57*, 64-93.]

Table 11

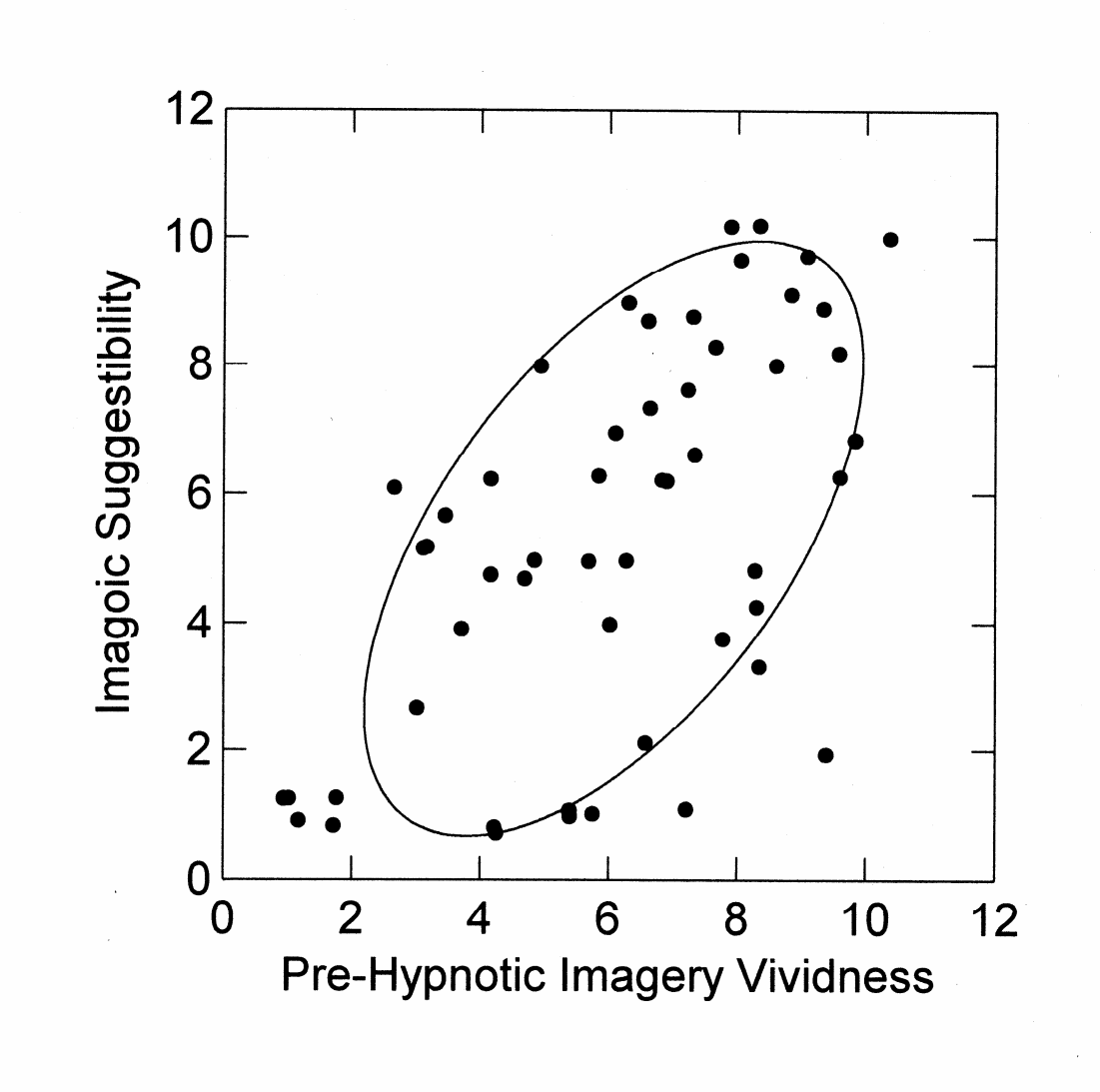
Predicting Hypnotic Imagoic Suggestibility from the PCI-HAP Items (excluding participants who failed to pass the finger response item)

Subscale	*R*	R^2	Unstandardized Coefficient	Standardized Coefficient	*F* Value[1]	*p* Value
Hypnoidal State Score	0.630	0.397	0.881	0.470	33.637	0.000
Pre-assessment Combined Imagery Vividness	0.726	0.527	0.486	0.394	13.648	0.001
Constant			-2.127			

[1]*F* and *p* are initial values for independent variables left in the regression equation.
[2]Varibles left out of the regression equation: fell asleep item, negative affect item, eye catalepsy item, combined hypnotic expectancy, nonhypnotic imagoic suggestibility, 5-item imagery vividness
n = 53

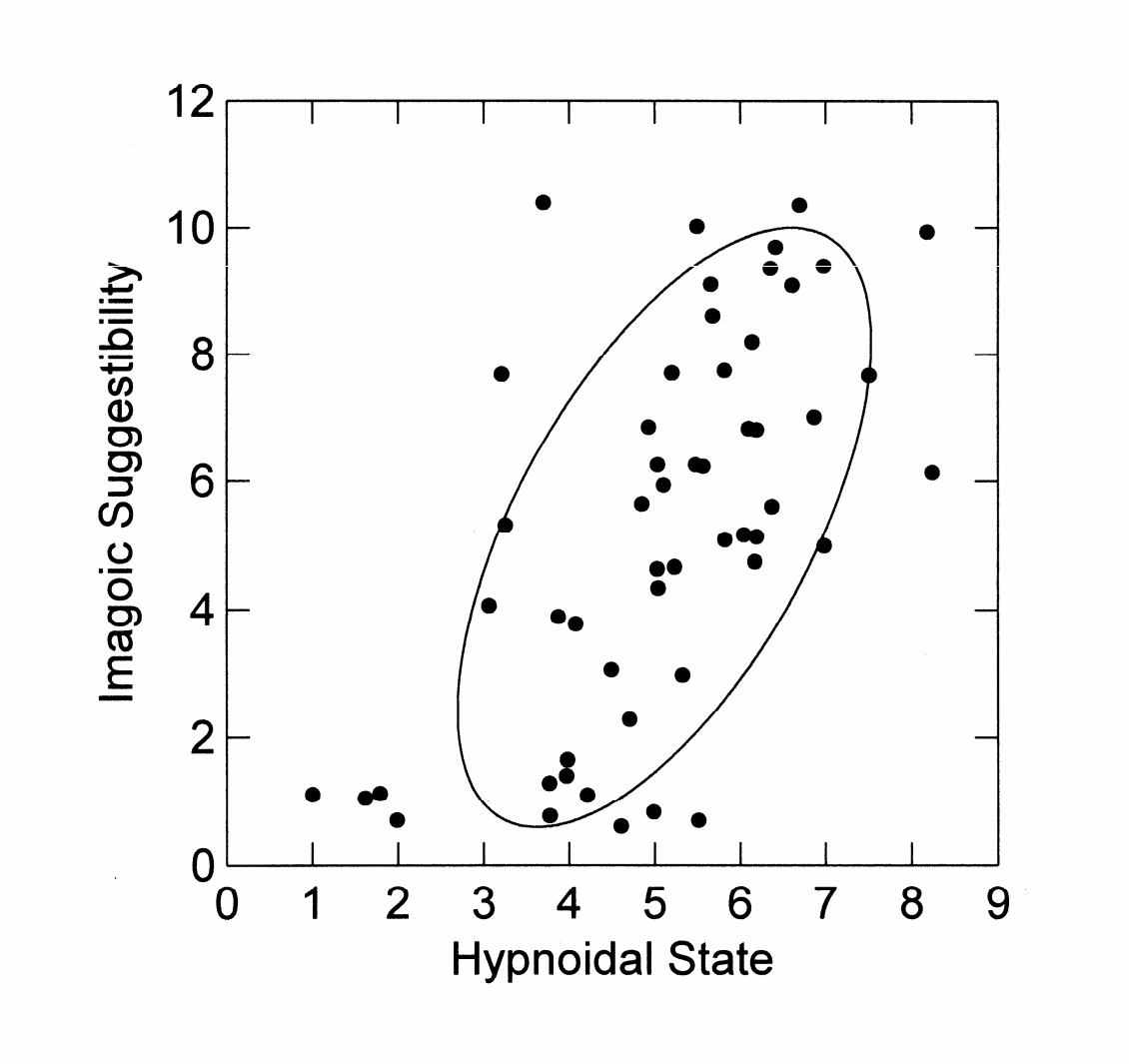
[From: Trance state effects and imagery vividness before and during a hypnotic assessment: A preliminary study (in press). *International Journal of Clinical and Experimental Hypnosis*.]

Figure 6
Imagoic Suggestibility as a Function of Prehypnotic Imagery Vividness (r = .59)



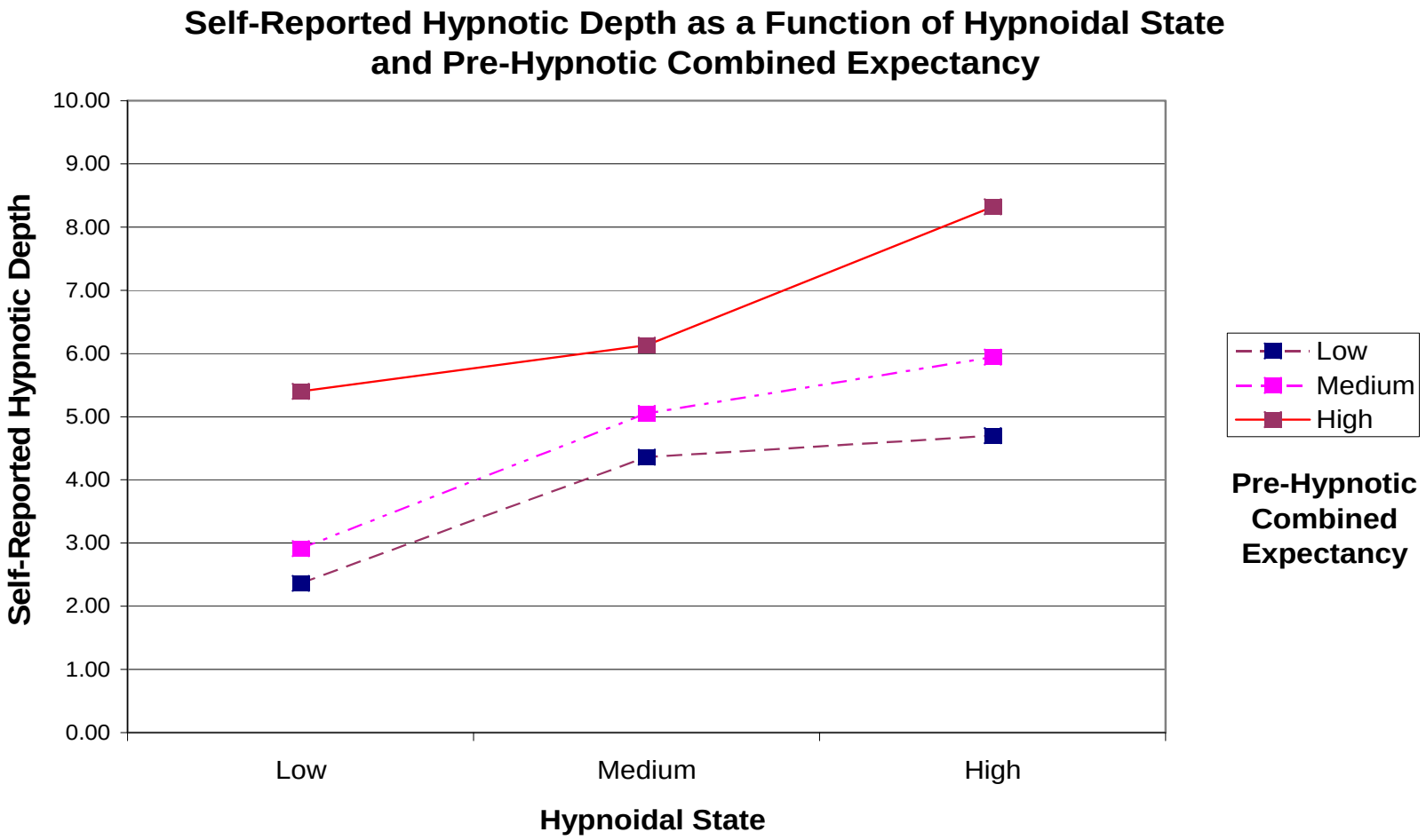
[From: Trance state effects and imagery vividness before and during a hypnotic assessment: A preliminary study (in press). *International Journal of Clinical and Experimental Hypnosis*.]

Figure 7
Imagoic Suggestibility as a Function of Hypnoidal State (r = .63)



[From: Trance state effects and imagery vividness before and during a hypnotic assessment: A preliminary study (in press). *International Journal of Clinical and Experimental Hypnosis*.]

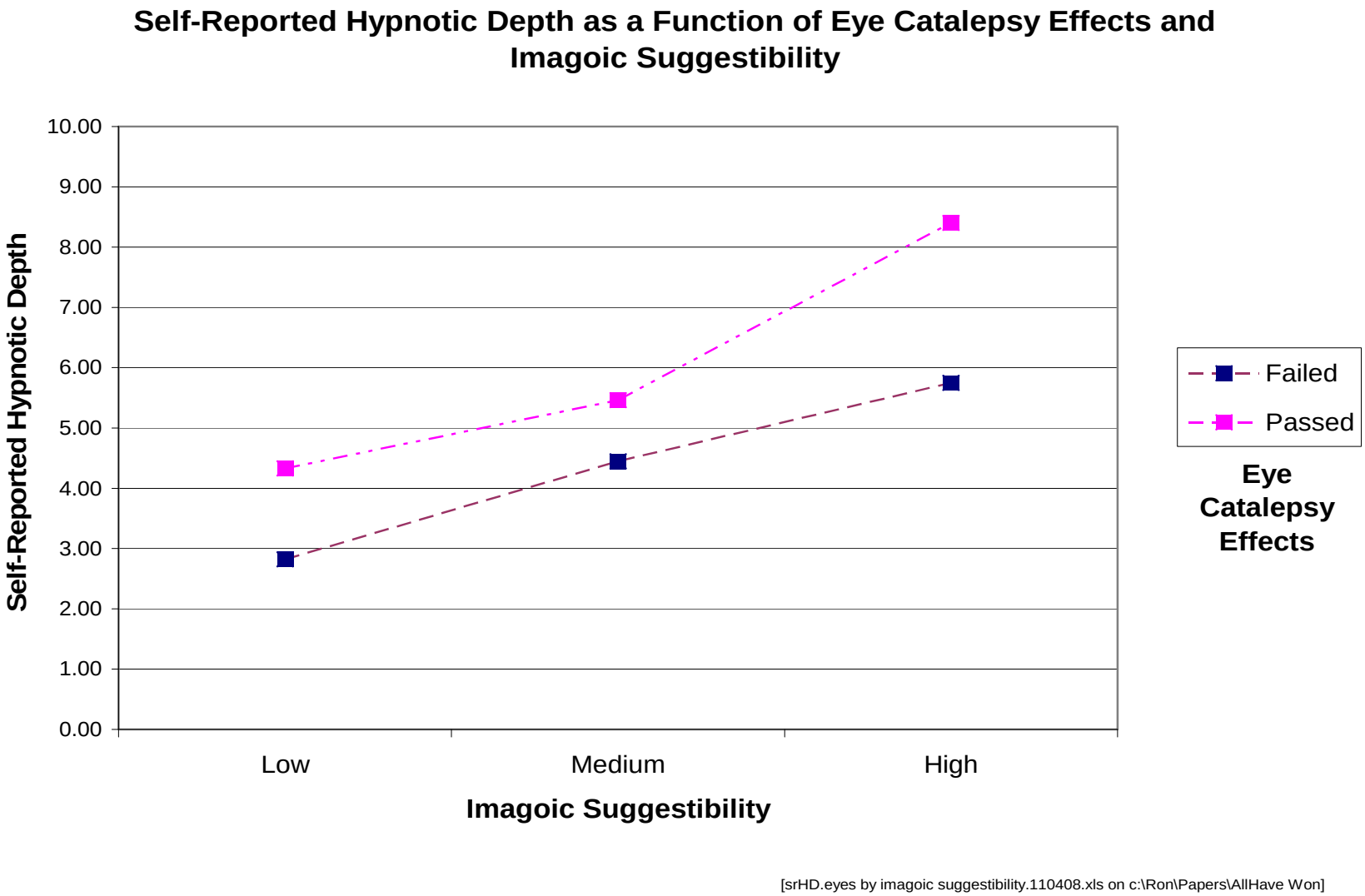
Figure 8



[srHD.hypnoidal state by expectancy.072608.xls on c:\Ron\Papers\AllHave Won]

[From: Self-Reported Hypnotic Depth as a Function of Suggestibility, Expectancy, and Trance State Effects: II. Assessment via the PCI-HAP. (2009c). Manuscript submitted for publication.]

Figure 9



[srHD.eyes by imagoic suggestibility.110408.xls on c:\Ron\Papers\AllHave Won]

[From: Self-Reported Hypnotic Depth as a Function of Suggestibility, Expectancy, and Trance State Effects: II. Assessment via the PCI-HAP. (2009c). Manuscript submitted for publication.]

Appendix B: Hypnotic Deepening Routine

Name: _____ _____ Last 4 SSN: _____ Date: _____

Time:

Time Started: _____ B/S: Comments: _____

M/C: 10 9 8 7 6 5 4 3 2 1 Depth: _____ _____

Comments:

Final Initial Ranking (rank order as to preference):

Going down a hillside towards the beach on a beautiful day

_____ _____ 20 19 18 17 16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1 Depth: _____ _____

Imagery Vividness: _____ Comments:

Going down a mountain towards a lake in a valley on a beautiful day

_____ _____ 20 19 18 17 16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1 Depth: _____ _____

Imagery Vividness: _____ Comments:

Going down a elevator

_____ _____ 20 19 18 17 16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1 Depth: _____ _____

Imagery Vividness: _____ Comments:

Going down an escalator

_____ _____ 20 19 18 17 16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1 Depth: _____ _____

Imagery Vividness: _____ Comments:

_____ _____ **Slow deep breathing into the chair** Depth: _____ _____

Imagery Vividness: _____ Comments:

Client suggestion: _____

_____ _____ 20 19 18 17 16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1 Depth: _____ _____

Imagery Vividness: _____ Comments:

Becoming a cloud

_____ _____ 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Depth: _____ _____

Imagery Vividness: _____ Comments:

Awakening: 1 2 3 4 5 6 7 _____

Total Duration: _____

Does stopping talking deepen _____, lessen _____, or make no difference _____ with trance depth?
Length of Pauses: _____ Comments

References

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