preventive health care, because studies have suggested that changes in mood and feelings can precede the onset of even established infection (Canter, 1972; Hall et al., 1978). People of low-hypnotic ability are nearly always limited to a skeptical, critical, and analytic mode of information processing; hence, they tend to negate (deny) or attenuate minimal sensory cues from their bodies. They are unwilling or unable to use verbal fantasy and imagination. It also appears that they prefer to think in concrete and discrete terms. Biofeedback instruments are helpful to low-hypnotizable subjects because they put their “insides” on the “outside” in observable, concrete, amplified, quantitative forms, such as meters that track the physiological correlates of psychological changes in ways that are harder to deny and dispute.

The low-hypnotic-ability person’s hypothesized hyposensitivity to psychological and physiological changes overlaps with the concept of alexithymia. Alexithymia is defined as lacking “words for moods” (Sifneos, 1972) and it was first identified in individuals with psychosomatic disorders. It is also strongly related to low hypnotizability. One study (Frankel, Apfel-Savitz, Nemiah, & Sifneos, 1977), (N=32) found that 73% of subjects demonstrating low hypnotizability were rated as alexithymic and only 27% were rated as nonalexithymic. Only 8% of subjects of superior hypnotic ability were rated alexithymic and 92% of them were rated nonalexithymic. The average hypnotizability score on the Harvard Scale was a very low 2.7 for alexithymics. For nonalexithymics the mean score was 6.9, which is much closer to the general

Figure 2. “This is incredible, doctor. I haven’t been able to cry in years.”