DEVELOPMENT OF A SELF-REPORT
MEASURE OF HYPNOTIC ABILITY:
PRELIMINARY FINDINGS

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AAPB/1985 New Orleans 1985
ABSTRACT

This is a report on the development and cross validation of a brief (24 item) true-false paper-and-pencil test to predict hypnotic ability. The test has been developed specifically to measure the hypnotic ability of patients who present physical complaints and who are committed to a somatic definition of their psychosocial distress. Hypnotic ability is assessed by inquiring about culturally acceptable altered states of consciousness and unusual experiences.
Development of a Self-Report Measure of Hypnotic Ability: Preliminary Findings

There have been numerous attempts to use standard self-report personality tests to predict hypnotic ability. These efforts have not been very successful (Hilgard, 1965; Barber, 1964). Efforts based on inquiring about hypnotic-like experiences that occur in everyday life (Shor, Orne, & O'Connell, 1962; As, 1963) and early childhood experiences (Hilgard, 1970) have been more successful (Tellegen and Atkinson, 1974). Yet, the amount of variance accounted for by this approach is insufficient for routine individual clinical prediction with even cooperative subjects.

There appear to be good theoretical and clinical reasons (Wickramasekera, 1979, 1983, 1984a, 1984b) to routinely and unobtrusively estimate the style of information processing or more specifically the hypnotic ability of all patients who present chronic stress related physical symptoms. I have noticed two things about patients who present with chronic stress related physical disorders without physical findings. First, they tend to be either high or low on hypnotic ability (Wickramasekera, 1979, 1983, 1984a, 1984b). Few of these patients are found in the middle range of hypnotic ability. Second, those who are high on hypnotic ability tend to either spontaneously report or if given permission, admit an unusually high base rate of naturally occurring altered states of consciousness and more specifically parapsychological incidents in their lives (Wickramasekera, 1979, 1980, 1983, 1984a, b). Wilson and Barber (1982) have independently confirmed the high base rate of parapsychological verbal reports in very high hypnotizable non-patients who they
described as "fastasy-prone personalities". There are also prior cogent reports relating hypnotic ability and the hypnotic state to superior performance of parapsychological tasks (Van De Castle, 1969; Honorton & Krippner, 1969).

Patients presenting somatic symptoms have an attitude toward psychological evaluations of any kind, and hypnotic tests in particular, that ranges from overt hostility to fearfulness based on either religious objection, false information about hypnosis, or simple unfamiliarity. Psychological tests appear to be a challenge to the authenticity of their physical symptoms. Their hostile attitude toward psychological investigations is based on the fact that these patients are committed to a somatic definition and presentation of psychosocial distress, and they will present only in a "medical" setting.

We have been searching for unobtrusive methods of assessing the hypnotic ability of all these somatically committed and non-psychologically minded patients even when they refuse to take a hypnotic test like the Harvard Group Scale. The present preliminary but promising approach is based on inquiring about naturally occurring altered states of consciousness (Evans, 1977) and culturally acceptable religious and parapsychological experiences, both conceptualized as unevenly distributed, naturally occurring skills or talents. The essence of this promising approach appears to be a repackaging of the manner in which we inquire about spontaneously occurring hypnotic phenomena in this non-psychologically minded group of patients.

The first version of the Wickramasekera-Armstrong (WA) Scale consisted of 46 true-false items like the ability to change dreams while they were occurring (lucid dreaming), to nap, to fall asleep easily, and to have religious con-
version experiences, etc. This first scale, WA, was administered exclusively to
patients with chronic stress related physical symptoms (e.g., headaches, low
back pain, irritable bowel syndrome, etc). It was followed by the Harvard
Scale, administered by the fourth author who was blind to the patient's score on
the Wickramasekera-Armstrong Scale (WA). Using all of a consecutive series of
64 unselected patients, we obtained a Pearson's r of .48 \( (p<.001) \).

Because of low correlations with the Harvard, 22 items were dropped and
other items were added or rewritten. The present version of the scale is called
the Wickramasekera-Armstrong-Thomas (WAT) Scale and is the basis of the present
report.

METHOD

The WAT is a 24-item, true-false paper-and-pencil test that inquires about
culturally acceptable, but unusual experiences and talents. A test-retest (6
weeks in between testing procedures) reliability correlation of .86 was obtained
using a sample of 51 college students and the WAT. The WAT test is now
routinely administered to all patients seen at the Eastern Virginia Medical
School Behavioral Medicine Clinic after the initial clinical interview with the
first author. It was given in this second study to a consecutive series of 53
unselected patients making somatic presentations.

The initial clinical interview is an abbreviated medical-behavioral history
and screen for psychosis. Before the interview the patients are told we are
evaluating their candidacy for "stress management therapy" and, to complete this
evaluation, they will need to take a few paper-and-pencil tests, the psychophysiological stress profile (Wickramasekera, 1976), and the Harvard Hypnotic ability test. The WAT was part of an approximately one hour, paper-and-pencil test battery. It was taken immediately after the clinical interview.

The Harvard was typically given one or two weeks later before any explicit clinical interventions were started, but after each subject had read the American Society for Clinical Hypnosis (ASCH) pamphlet "An Old Art Returns to Medicine" (Heron & Hershman, 1958). This pamphlet presents questions and answers about hypnosis and tries to reduce anxieties about hypnosis and correct misconceptions. The Harvard Scale was administered by the fourth author (who was blind to the patient's WAT score) in a group situation (2-4 patients).

RESULTS

A Pearson's r correlation of .55 (p<.001) between a consecutive series of all 53 Harvard scores and the WAT was found using SPSS software on a DEC PDP-11. Test items on the WAT were further divided based on rationally derived content categories to determine if a certain category better discriminated among high (Harvard 9-12) and low (Harvard 0-3) Harvard scores. Table 1 shows category discrimination in terms of the percentage of true responses within a particular category and level of hypnotic ability for the average patient. It appears that for this sample the items in the category "Parapsychological Experience" best discriminate between high and low hypnotic ability scores and the items in the category "Memory" least discriminate between high and low hypnotic ability scores.
DISCUSSION

The very preliminary character of these empirical observations cannot be overemphasized even though they are based on good theoretical reasons and promising clinical observations of intervention (Wickramasekera, 1979, 1983, 1984a, 1984b). First, it is not known if this correlation will hold for a third replication with a consecutive series of patients. It is encouraging to note that the correlation (validity coefficient) has in fact improved with even a smaller number of patients and a smaller number of test items. Second, our results may simply be related to patient willingness to say "yes" to unusual experiences and have nothing to do with hypnotic ability (Hilgard, 1965).

These WAT scores may be related to undetected psychopathology, but this is unlikely because each patient is carefully screened for psychopathology and given a DSM III diagnosis. The clinical interview was done by the first author, who is a diplomate in clinical psychology and has worked extensively with psychotic patients in state hospitals. None of our patients received a psychotic diagnosis and all of them have contraindicating social histories. Also, because of a very low drop-out rate, we were able to follow these patients for several months during active psychophysiological therapy (Wickramasekera, 1976) and later for several years (1-5) during our required long-term follow-up to further verify clinically both their hypnotic ability and their non-psychotic status. Because of the selective nature of our sample, we do not yet know if these results of the Harvard and WAT will replicate only with normal (non-psychiatric) subjects and medical (physically presenting) patients.
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If the observation that parapsychological experience, absorption, and hypersensitivity to sensory stimuli replicate as the best discriminators of Harvard scores, it may provide a new and heuristic way of conceptualizing and intervening with at least a subset of people that bear the pejorative label hypochondriac or "crock". It is just possible that high hypnotic ability is a risk factor for developing somatic symptoms in some people who have unusual, unassimilated (McReynolds, 1960) perceptual experiences. We have found that when these parapsychological experiences are elicited in a trusting relationship and cognitively reframed in more naturalistic ways, there is a dramatic remission of somatic symptoms. Also, absorption focused on sensory stimuli may be related to lower sensory thresholds and may be the mechanism through which psychological factors can potentiate sensory signals in the highly hypnotizable.
TABLE 1

Components (Test Items) of the Wickram-Armstrong-Thomas Scale That Predict Hypnotic Talent

<table>
<thead>
<tr>
<th>Components</th>
<th>True Responses</th>
<th>Hypnotic Ability*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parapsychological Experience</td>
<td>19%</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>71%</td>
<td>High</td>
</tr>
<tr>
<td>Absorption</td>
<td>34%</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>84%</td>
<td>High</td>
</tr>
<tr>
<td>Hypersensitivity to Sensory Stimuli</td>
<td>22%</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>65%</td>
<td>High</td>
</tr>
<tr>
<td>Fantasy</td>
<td>8%</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>50%</td>
<td>High</td>
</tr>
<tr>
<td>Control of Altered States of Consciousness</td>
<td>25%</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>63%</td>
<td>High</td>
</tr>
<tr>
<td>Hallucinations</td>
<td>11%</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>42%</td>
<td>High</td>
</tr>
<tr>
<td>Empathy</td>
<td>62%</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>84%</td>
<td>High</td>
</tr>
<tr>
<td>Memory</td>
<td>25%</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>34%</td>
<td>High</td>
</tr>
</tbody>
</table>

*Low (Harvard 0-3)  
High (Harvard 9-12)
References


Footnotes

1 The authors would like to thank Ronald Giannetti, Ph.D. for his editorial comments and Karen Thomas for her technical assistance.

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