

This paper examines the extent to which belief influences the outcome of therapy. It is based on a study of patients receiving treatment for psychological problems including smoking, obesity and stress.

Patients were questioned at each session about post-hypnotic amnesia, the state of awareness and relaxation during hypnosis, global impression of the hypnotic session, and belief in the effectiveness of hypnotherapy.

The responses were quantified on a scale in which the most desirable state – complete relaxation, no awareness, total amnesia, excellent global impression, and total belief – yielded the lowest score, whereas the least desirable state – no relaxation, full awareness, no amnesia, poor global impression, and lack of belief – corresponded with the highest score.

Each patient was also assigned a progress rating (minimum points for very good progress, maximum points for poor progress) by the therapist on completion of treatment.

In a group of 18 patients, progress was found to be correlated with Mean Relaxation Score (MRXS, $p < 0.05$), Mean Awareness Score (MAWS, $p < 0.01$), Mean Global Impression Score (MGIS, $p < 0.05$), and Mean Belief Level Score (MBLS, $p < 0.05$), but not with the mean amnesia score (MAMS).

When the belief level of patients was examined for a possible association with other parameters, MBLS was found to be correlated with MGIS ($p < 0.001$) and MAWS ($p < 0.01$) but not with MRXS. Similarly, the MGIS of patients was correlated with MAWS, but not with MRXS.

The results suggest that belief in hypnosis and relaxation during hypnosis are independent factors which act directly to increase post-hypnotic progress.

An indirect influence on progress is exerted by lack of awareness of one's surroundings during hypnosis, which improves the global impression and increases belief. In contrast, post-hypnotic amnesia does not influence progress either directly or indirectly. It is concluded that belief plays a key role in hypnotherapy.

The key role of belief in hypnotherapy

By

Firoz Mohamed M.Sc., M.Phil.



Firoz Mohamed M.Sc., M.Phil,

A hypnotherapist/psychotherapist in Glossop, England. Trained as a clinical scientist at Southampton University and the Royal Postgraduate Medical School, he is also a freelance medical writer.

Correspondence to:

F.I. MOHAMED M.Sc., M.Phil.
285 Sheffield Road,
Glossop, Derbyshire,
SK13 8QY, England, U.K.
Tel. (0457) 853036

Medical science in general, and clinical psychology in particular, acknowledges the role of belief in treatment. Placebo controls and double-blind trials are thus held to be absolutely essential for testing new drugs or novel procedures because it is well recognised that a patient's response to therapy of any kind may be influenced in some measure by his belief in its efficacy.

This influence of belief on the outcome of treatment would appear to be particularly true in the case of hypnosis which involves a suppression of the power of criticism and an enhancement of the suggestibility of the subject. As Hartland (1966a)¹ points out, Mesmer's cures depended not upon iron rods or magnetic fluids, but upon the implicit belief in recovery that was instilled in the patient's mind because his suggestibility had been greatly increased by the mysterious ritual and ceremonial. He adds that analytically-minded people who question everything are unlikely to be good hypnotic subjects in his experience.

¹ Hartland, J. (1966a), Reprint 1984 (2nd Ed.), *Medical & Dental Hypnosis - Its Clinical Applications* Bailliere Tindall, pp. 12, 27.

² Golan, H.P. (1986), *Ibid.* p. 88.

³ Murray-Jobsis, J.M. (1986), in Zilbergeld, B., Edelstein, M.G., & Araoz, D.L., Eds., *Hypnosis - Questions & Answers*, Norton, Lond. p. 92.

In a similar vein, Golan (1986)² emphasises how a 'poisoned referral' from a sceptical clinician can cause doubt which impedes a patient's progress in hypnosis. Having failed to cure his patient, the doctor may suggest hypnosis as a last resort, adding that he does not really believe it will help, thus eroding the patient's belief and decreasing his ability to respond to therapy. Murray-Jobsis (1986)³ also notes the negative effect of ambivalent feelings about hypnosis on therapeutic outcome.

These observations may come as no surprise to most practitioners who hold it as self-evident that the patient must *want and expect it to happen*. Clearly, belief plays an important role in hypnotherapy.

The present study was designed to investigate this hypothesis further in a systematic and accurate way which relied entirely on the patient's own subjective assessment of his belief in, and impression of, the therapy.

All responses from patients were obtained by means of a standardised questionnaire with a numerical score assigned to each reply in order to ensure uniformity and reliability in assessing various parameters.

In general, the present investigation was designed to reveal the inter-relationships, if any, between the patient's judgment of his own state of hypnosis, his belief in the effectiveness of hypnotherapy, and his progress.

⁴ Mohamed, F.I. (1987), *A Case of AIDS Phobia*, *The Register (Journal of the National Register of Hypnotherapists & Psychotherapists)*, Spring/Summer, pp.7-11.

⁵ Mohamed, F.I. (1988), *Vivid Body Imagery in the Treatment of the Obese Patient*, *The Register (Journal of the National Register of Hypnotherapists & Psychotherapists)*, pp 9-12.

Methods

Eighteen patients (six male; mean age, 39.6 years, range 15.7–63.4 years (mean \pm 2 S.D.)) receiving treatment for stress, compulsive smoking, compulsive eating, phobias, lack of confidence, and sexual problems were questioned during each session. Each was questioned about post-hypnotic amnesia, states of awareness and relaxation during hypnosis. Patients were also asked about their global impression of the hypnotherapy session and belief in the effectiveness of hypnotherapy.

For each question, the patient had to select an appropriate reply from a set of standardised replies (Tables I - V). If the patient was unable to decide between two statements (e.g. one rated at 2 points and another at 3 points) then the score was deemed to be the mean of the scores for the two statements (e.g. 2.5).

Progress (Table VI) was assessed by the therapist either when the patient was discharged after completion of treatment, or when the patient terminated treatment of his own volition.

As the assessment of progress depended entirely on the patient's own reports, only those patients who had more than two therapy sessions were included in the study because those who required only two sessions never returned to report on their progress (e.g. habit smokers), and those who needed more sessions but did not have them were judged to have had insufficient therapy for progress monitoring.

The details of the hypnotic procedure were essentially as outlined previously (Mohamed, 1987, 1988).^{4/5}

Patient's response	Score
Very relaxed	1
Quite relaxed	2
Bit relaxed	3
Not relaxed	4

Table I. Degree of relaxation during hypnosis
Table I. Degree of relaxation during hypnosis

Patient's response	Score
Cannot remember anything	1
Can only remember a little	2
Can remember about half	3
Can remember almost everything	4
Can remember everything	5

Table III. Degree of posthypnotic amnesia
Table III. Degree of post-hypnotic amnesia

Patient's response	Score
I believe hypnotherapy works. I am sure it will help me / continue to help me	1
I have an open mind about hypnotherapy. It may help me	2
I am rather sceptical about hypnotherapy. I am prepared to give it a try	3
I don't see how hypnotherapy can help me personally	4

Table V. Belief in effectiveness of hypnotherapy
Table V. Belief in effectiveness of hypnotherapy

Parameter	r	p
Mean relaxation score	0.4974	<0.05
Mean awareness score	0.5940	<0.01
Mean amnesia score	0.1882	N.S.
Mean global impression score	0.5501	<0.05
Mean belief level score	0.4889	<0.05

Table VII. Correlations with patient's progress
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Abbreviations: r = coefficient of correlation
p = Level of significance
N.S. = Not significant (p > 0.05)
N.S. = Not significant (p > 0.05)

Parameter	r	p
Mean relaxation score	0.2473	N.S.
Mean awareness score	0.6096	<0.01
Mean amnesia score	0.3299	N.S.

Table IX. Correlations with belief

Results

As shown in Table VII, lack of awareness during hypnosis was strongly correlated with progress. The state of relaxation during hypnosis, global impression of hypnosis and belief in the effectiveness of hypnotherapy were also correlated with progress.

It is noteworthy that the mean amnesia score was not significantly correlated with progress.

Table VIII shows that the global impression of hypnosis was very strongly correlated with belief, strongly correlated with lack of awareness during hypnosis, but not correlated with either degree of relaxation or degree of amnesia.

Similarly, Table IX shows that the mean belief level score was strongly correlated with the mean awareness score, but not significantly correlated with either mean relaxation score or mean amnesia score.

A majority of the patients (77.8 per cent.) had a MAMS of 2-4 (Table X). Thus most patients' recall of the hypnotic procedure was by no means small. A substantial degree of posthypnotic amnesia was reported by only 22.2 per cent of the patients.

Patient's response	Score
Not aware of anything	1
Partly aware	2
Fully aware	3

Table II. Degree of awareness of the immediate environment during hypnosis
Table II. Degree of awareness of the immediate environment during hypnosis

Patient's response	Score
Very impressed	1
Quite impressed	2
Neither impressed nor disappointed	3
Quite disappointed	4
Very Disappointed	5

Table IV. Global impression of hypnotic session
Table IV. Global impression of hypnotic session

Progress	Score
Very good	1
Good	2
Fair	3
Poor	4

Table VI. Patient's progress scale.

Parameter	r	p
Mean relaxation score	0.3918	N.S.
Mean awareness score	0.6816	<0.01
Mean amnesia score	0.3934	N.S.
Mean belief level score	0.8967	<0.001

Table VIII. Correlations with global impression
Table VIII. Correlations with global impression

Mean amnesia score	0 - 1	1 - 2	2 - 3	3 - 4	4 - 5
% of population	0.00	22.2	66.7	11.1	00.0

Table X. Mean amnesia score - population distribution

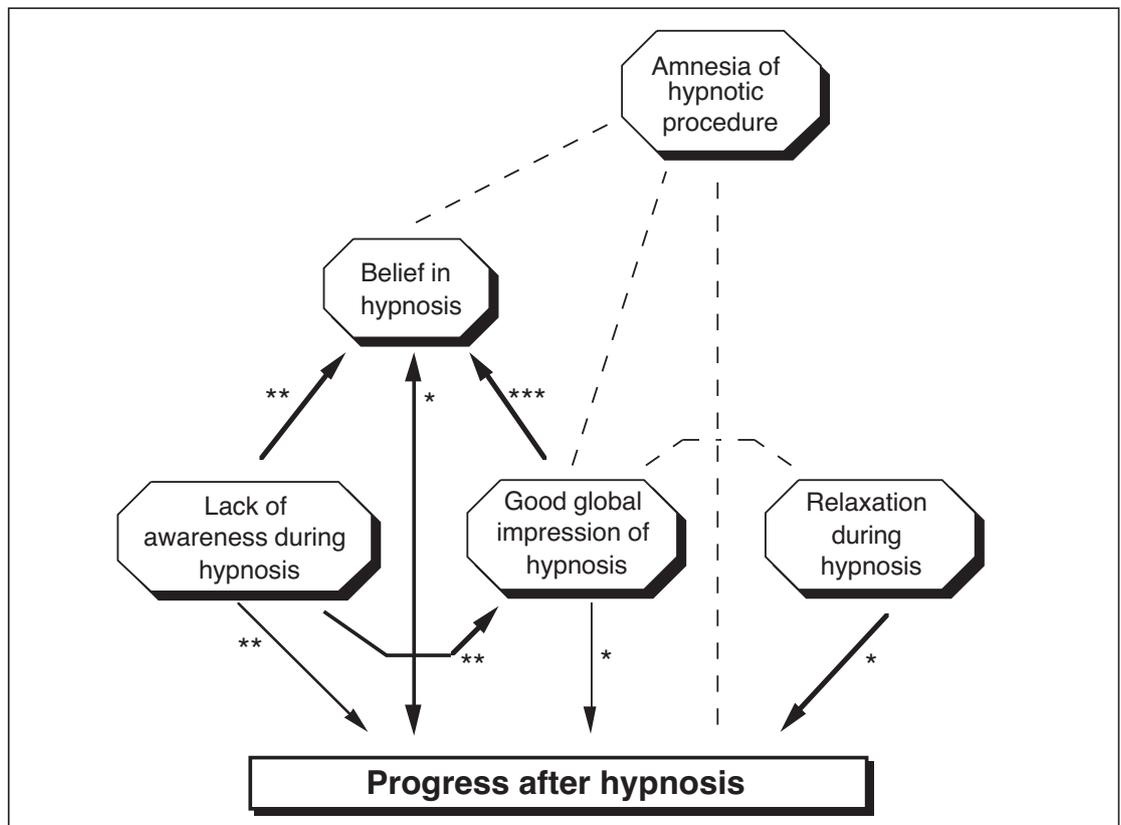


Figure 1 The key role of belief in hypnotherapy

Bold arrows indicate a direct influence.

Other arrows indicate an indirect influence.

Dotted lines indicate no influence (correlation coefficient not significant ($p > 0.05$)).

* = $p < 0.05$ (acceptable correlation)

** = $p < 0.01$ (good correlation)

*** = $p < 0.001$ (very good correlation)

DISCUSSION

The two most important factors influencing post-hypnotic progress – relaxation during hypnosis and belief in hypnosis (Figure 1) – would appear to act independently as there is no correlation between them.

Belief, which makes subjects susceptible to hypnosis, can be thought of on a simplistic level as the key which opens the gates of the subconscious mind to make it accessible to the therapist. If the gates cannot be opened as in the case of a cynic, then the subconscious is totally impervious to

suggestion. The correlation between mean relaxation score and progress is also to be expected if hypnosis is defined as a state of relaxation. It is common knowledge that a patient who relaxes well during hypnosis (i.e. one who achieves a deep state of hypnosis) has a good prognosis.

Clearly, since belief in hypnosis and depth of hypnosis are independent factors, it is possible for a cynic to achieve a deep hypnotic state. His consequent post-hypnotic progress may well initiate his belief and increase his subsequent progress. Thus, belief may influence progress which may, in turn, influence belief.

⁶ Hartland, J. (1966b), *Reprint 1984 (2nd Ed.)*, *Medical & Dental Hypnosis – Its Clinical Applications*, Bailliere Tindall, p. 166.

⁷ Evans, F.J. (1986), in Zilbergeld, B., Edelstein, M.G., & Araoz, D.L., Eds., *Hypnosis – Questions & Answers*, W.W. Norton, pp. 173–180.

The two other factors which are correlated with progress, viz., lack of awareness of the immediate environment during hypnosis and a good global impression of the hypnotic procedure, probably do not influence progress directly. Both are not only correlated with belief but are easy to conceive of as factors influencing it. A man who finds that he is partly or fully unaware of his environment during hypnosis is clearly more likely to believe that the therapy is altering his mind in some way than one who is fully aware during the procedure. The former would also be expected to have a better global impression of the hypnotherapy session (as confirmed by the good correlation between MAWS and MGIS), and a greater belief in hypnosis (as confirmed by the very good correlation between MGIS and MBLs).

Post-hypnotic amnesia, which might also be expected to impress the patient, had no influence on belief, progress, or global impression in the present study, probably because the degree of amnesia in most patients was not very high (Table X).

In fact, only about a fifth of the patients reported that they could remember a little or nothing at all of the hypnotic procedure. The rest had quite a substantial recall of what was said and done during hypnosis. Furthermore, post-hypnotic amnesia was not emphasised pre-hypnotically in any way.

No patient was told that it was important to forget, or that forgetting implied a deep trance. Even during hypnosis, the only suggestion with regard to post-hypnotic amnesia was mild and permissive.

“Forgetting what you heard during hypnosis is a perfectly normal process ... It is easy to forget if you divert your attention to other things ... Last time you forgot certain things whilst you were in this type of relaxed state ... Today you will probably forget many more things ...”

It is questionable whether a stronger and more authoritative suggestion would have produced better results. As Hartland (1966b)⁶ observes, amnesia will only arise if the subject has no conscious or unconscious objection to it. He adds that the more important memory is to a subject in his occupation, the more difficulty there is likely to be in successfully inducing amnesia. He concludes that complete amnesia is very useful when it can be achieved.

In contrast, Evans (1986)⁷ believes that post-hypnotic amnesia is only rarely necessary or even appropriate in clinical practice. He argues that ‘if the patient can accept that the compulsive drive to carry out a post-hypnotic suggestion does not need to be protected by an amnesic barrier, then post-hypnotic behaviour is no longer contingent on an equally difficult suggestion to forget the origins of the suggestion itself.’ Thus post-hypnotic amnesia occurs only if the patient believes that it is a necessary prerequisite for successful hypnotherapy.

In view of these observations and the findings of the present study, it would appear that, in general, post-hypnotic amnesia does not have a very important role in clinical hypnosis.

Belief, on the other hand, appears to have a key role in influencing the outcome of hypnotherapy. If hypnosis is defined as a state of relaxation, then belief does not affect hypnosis *per se*, but it does influence the way in which a patient will respond to it.

On a practical level, it follows that a patient who believes in hypnosis may respond to a light hypnotic state to which a cynic may not respond at all.

As deep hypnotic trances are not frequently encountered in routine clinical practice, it would be appropriate to conclude that belief is the most important factor influencing progress in hypnotherapy

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