

## **IMPACT ON HEALTH STATUS OF A HYPNOSIS CLINIC IN GENERAL PRACTICE**

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### **Abstract**

The impact on health status of hypnosis was investigated in a primary care NHS GP surgery clinic, with referrals from a Local Health Care Cooperative (LHCC) with 85,000 patients. The Medical Outcomes Study Short Form-36 Health Survey (SF36) pre and post treatment was completed by patients referred with mental health problems, medical problems and for smoking cessation. One hundred and fifteen patients successfully completed SF36 questionnaires before and six weeks after the intervention. Categories of treatment were smoking cessation, mental health, and medical. In the case of referrals for smoking cessation there were no significant changes in mental, social or physical function six weeks after the intervention. In the case of mental health referrals, which were predominantly anxiety related, there was a large and significant effect on the SF-36 in emotional role and mental role and a moderate effect on social role and mental health. Self-hypnosis was in widespread use after treatment, even in those whose perceived problem appeared not to have improved. The results suggest that simple hypnosis techniques could have a significant impact on mental health. This could have implications for promoting mental health as well as for treating mental illness, and needs to be tested further by a randomized, controlled trial.

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**Key words:** general practice, hypnosis, hypnotherapy, mental health, smoking

### **Introduction**

Hypnosis is a treatment complex of induction and deepening, producing an altered mental state with probable neurophysiological correlates (Gruzelier, 1998). It may then additionally consist of a selection of techniques such as:

- 1) general raising of self-esteem and confidence using suggestions of inner strength and coping ('ego strengthening');
- 2) a post hypnotic suggestion using a conditioned reflex to improve mental state by a positive visualization of a safe place, or a coping style, or both, which can be accessed by simple cues ('self-hypnosis');
- 3) psychodynamic tools for the specific problem (see hypnosis techniques).

Ego strengthening has been shown in experimental trials to improve the Beck Depression Index-II (BDI-II) (Laverture, Kumar and Pekala, 2002). Positive words increase the ability to cope in stressful situations (Levy and Hausdorff, 2000); and older people exposed to subliminal positive words walk more steadily and are cognitively improved (Levy, Ashman and Dror, 1999). It has also been shown that hypnotic visualization improves the HADS scale in clinical studies using taped hypnosis (Gruzelier, Champion, Fox, Rollin, McCormack, Catalan, Barton and Henderson, 2002). Research examining the way CBT works, has found that it reduces relapse in depression 'by changing relationships to negative thoughts rather than by changing belief in thought content' (Teasdale et al., 2002). Watkins and Teasdale (2001) showed that simple exercises of reduced self-focus and visualization were effective in reducing overgeneral memory in depression. Many other hypnosis techniques are very similar to CBT techniques, involving changes in patterns of thought. A meta-analysis concluded that the use of hypnosis as an adjunct to CBT significantly benefited over 70% of clients (Schoenberger, 2000). Hypnosis may also harness the considerably powerful placebo effect. The placebo effect is most potent when administered by 'physicians who adopt a warm, friendly and reassuring manner' (Feldman, 1956: 53). It is likely that the placebos reveal the 'self confirming nature of response expectancies', and that hypnosis can 'exploit the therapeutic mechanism underlying placebo effects without deceiving our clients' (Kirsch, 1996: 112). The benefits of self-hypnosis have been shown to be effective in sport (Unestahl and Briefe, 1981).

Much hypnosis research focuses on single outcome measurement (i.e. success or failure) without examination of any global changes or the holistic spread of the benefits of hypnosis into other physical/psychological/social domains. The Medical Outcomes Study Short Form-36 Health Survey UK version (SF-36) is a general health status self-report measure that assesses eight domains: physical functioning, role functioning due to physical problems (physical role), bodily pain, general health, vitality, social functioning, role functioning due to emotional problems (emotional role), and mental health. Each domain is scored on a scale from 0 to 100, with a score of 100 indicating best health. The SF-36 has proven to be useful in estimating the relative health burden of different conditions, including mental disorders, and in assessing the impact of associated treatments (Adler et al., 2000). There are no studies using the SF-36 in hypnosis, but one study of meditation use in stress reduction showed moderate changes in SF-36 (Reibel, Greerson, Brainard and Rosenweig, 2001). Adler et al. (2000) examining referrals to a psychiatric department found the SF-36 a useful predictor of psychiatric morbidity, particularly the 'mental health' (mh) scores. They devised a cut-off score of 52/100 points; below this point there was a 'high probability of clinical depression or other psychiatric disorder' (p. 346). It is widely acknowledged among practitioners of hypnosis, although unproven, that the simple tool of ego strengthening may appear to solve complex psychodynamic problems economically and quickly. However, a literature search on Psychinfo reveals only one paper on hypnosis in general practice (Sogarman, 1996).

A clinical review in the British Medical Journal (BMJ) discussing generalized anxiety disorder stated 'providing evidence based mental health care can be difficult. In addition to the problem of publication bias there is a considerable debate in psychiatry as to how to define an acceptable outcome' (Gale, 2003: 701). A recent study reported in the BMJ on the treatment of depression in primary care using the SF-36 as a measuring tool showed a 26 point (77%) improvement in 'role emotional' functioning for the 'enhanced treatment' group at 6 months (Rost, Nutting, Smith, Elliott and Dickinson, 2002).

Much hypnosis research is done in laboratories, while most clinical papers come from hospital clinics. Research in general practice may yield very different results to those in psychiatric practice. The aim of this study is to investigate the effect of a simple classical model of hypnosis in a GP referral system in the NHS by examining the physical, emotional, mental and social effects of hypnosis in the treatment of anxiety related conditions, medical conditions and smoking cessation. Data on desired outcome, enablement (Howie, Heaney, Maxwell, Walker, Freeman and Rai, 1999) and the continuing use of the psychodynamic tools provided by the general practitioner were also collated.

## **Method**

### *Participants*

Sixty-five general practitioners (GPs) in 14 general practices in one LHCC in northeast Edinburgh were invited to refer patients to a 'hypnosis clinic'. There were only two exclusion criteria: severe depression (active suicidal ideation) and psychosis. The population covered was 85,000. Funding came from the LHCC, and was entirely free to patients including any taped material. A standard explanation sheet informed the subject what to expect and requested that they phoned to make an appointment. Subjects were booked at half-hour intervals, and requested to arrive 15 minutes early to complete forms.

### *Hypnosis techniques*

Each session took half an hour. All subgroups (medical, mental health and smoking) were hypnotized in the first two sessions by distraction (observing a pen held above the eyes) and progressive muscular relaxation, followed by ego strengthening and encouraging ego state problem solving and healing (with some reference to the problem, i.e. anxiety 'safe and secure', irritable bowel 'calm and comfortable'). A relaxation and ego-strengthening tape (standardized) was given after the first session, except to smokers who were given a specific smoking visualization tape. The second session taught self-hypnosis using a post hypnotic suggestion of a word sequence to trigger the relaxed state. Following this standardized procedure, the specific further work for the individual therapies were all neurolinguistic programming (NLP) type exercises involving positive reframing of negative emotions (anger/fear). Smokers were confined to two sessions, the second session using ego state therapy and visualization to let the non-smoker inside take control. Apart from the 6-week follow up there was a 1-year telephone follow up of smokers. Patients referred with anxiety and panic were administered a psychodynamic remodelling exercise to let go of anger from childhood, devised by Donald Ebrahim (part of his 'traumatic separation' model; Ebrahim, 2002). Patients referred with phobia were administered the exercise from *Frogs into Princes* (Bandler and Grindler, 1979). Flying phobias also used a future visualization exercise. All medical conditions were treated with three sessions, the first two as before with self-hypnosis on the second session and the third a specific one to encourage specific visualizations related to the condition.

## **Measurements**

Patients attending were asked to complete two forms before seeing the doctor, while sitting in the waiting room. One was the SF-36, the other had three specific questions asking for: 1) their main objective; 2) anything else they would like to change; and 3)

what they would most like to be able to do. Six weeks after attending all patients were sent a follow up SF-36, an enablement questionnaire based on similar questionnaires widely used to compare styles of GP treatment, and 4 specific questions on objectives and self-hypnosis. All questionnaires were returned to an independent primary care researcher for data analysis with one follow up of non-responders.

Data were analysed using Stata 7.0. Descriptive results of categorical data are presented as percentages and SF-36 questionnaire data are presented as means (SD). As the data were not normally distributed, the Wilcoxon signed rank test was used to assess the statistical significance of changes from baseline.  $P > 0.05$  was considered significant.

## Results

Four hundred clients were referred of which 300 contacted us for an appointment. Of the referrals, 260 were female and 140 male. Of the attendees, 208 were female and 92 were male. The average age of attendees was 39.7 years (SD = 14.8, median = 37.7, interquartile range = 29.4 to 51.5). Two hundred and forty-four patients completed their basic two treatments. One hundred and ninety-nine were sent a follow up questionnaire 6 weeks after the intervention, 126 (65%) patients completed this and 115 (60%) patients successfully completed SF-36 questionnaires before and 6 weeks after the intervention: 44 in the mental health group, 42 in the smoking group and 29 in the medical group.

Table 1 shows the responses to the questions in the follow up questionnaire. At six weeks 44% of the responders reported that hypnosis had achieved what they wanted it to achieve. Just over a quarter of the smokers had given up. However, over three quarters of

**Table 1.** Responses to the questions in the follow up questionnaire

Question	Percentage			
	Yes	No	Ambivalent	n
Has the hypnosis achieved what you wanted it to achieve?	44	37	19	125
Have you stopped smoking?	27	73	N/A	44
Has your life changed in any other ways for the better?	62	35	3	112
Are you still using your self-hypnosis?	77	23	N/A	123
Have you noticed any bad effects from the hypnosis?	1	99	N/A	123
As a result of your hypnosis do you feel you are:				
	Much better or better?	Same or less?	Not applicable	n
able to cope with life	60	33	7	121
able to understand your problem	67	28	5	123
able to cope with your problem	65	31	4	123
able to keep yourself healthy	41	50	9	119
able to help yourself	65	31	4	120
confident about your health	45	50	5	120

responders were still using the techniques learnt, and only one responder noted any bad effects. The results of the enablement questionnaire were positive: previously this measure had been used immediately after a GP consultation so comparison is difficult, but over 60% of the responders reported being more able to cope with life, more able to understand their problem, more able to cope with their problem and more able to help themselves.

Table 2 shows before and after scores for the SF-36 domains in this study along with normal population scores. Significant improvements at 1% level were recorded for the mental health subgroup in the following SF-36 domains: emotional role, social function, mental health and energy value; and for the medical subgroup in the SF-36 domain: mental health (with several other of the domains in the medical subgroup approaching significance) but there were no significant differences in the smoking subgroup. We did not attempt to investigate whether responses to the follow up questions, or changes in health status were associated with patient characteristics (age and sex) with the sample size of this study. We followed up smokers at one year by telephone: 4 patients out of 40 identified smoking cessation referrals had given up smoking.

**Table 2.** SF-36 summary at baseline and follow up by treatment groups

	Normal		Baseline		Follow up	
	N = 6301	Mean	Std Dev	Mean	Std Dev	p-value
Mental health (n = 44)						
Physical function	92.5	82.74	(23.4)	83.21	(24.0)	0.4440
Physical role	91.4	55.81	(45.3)	68.18	(41.9)	0.1265
Emotional role	85.6	36.43	(37.7)	66.67	(41.3)	0.0001
Social function	91.3	56.06	(29.9)	69.51	(31.7)	0.0003
Mental health	75.4	48.91	(19.8)	61.18	(20.4)	0.0001
Energy value	64.0	43.86	(21.0)	52.27	(23.4)	0.0013
Pain perception	86.3	67.12	(22.0)	67.59	(24.6)	0.7800
Smoking (n = 46)						
Physical function	92.5	70.12	(29.9)	69.15	(32.8)	0.3422
Physical role	91.4	60.37	(42.9)	56.55	(45.9)	0.9798
Emotional role	85.6	57.89	(43.6)	58.14	(46.1)	0.1270
Social function	91.3	66.67	(28.5)	64.81	(31.2)	0.9118
Mental health	75.4	57.45	(17.7)	59.18	(20.8)	0.2836
Energy value	64.0	46.05	(18.9)	48.93	(19.6)	0.3623
Pain perception	86.3	64.79	(23.7)	61.93	(23.2)	0.2277
Medical (n = 29)						
Physical function	92.5	78.04	(28.4)	80.18	(29.4)	0.2345
Physical role	91.4	61.11	(40.6)	63.79	(41.5)	0.4467
Emotional role	85.6	50.00	(42.1)	63.22	(43.0)	0.0568
Social function	91.3	55.16	(26.4)	66.67	(31.6)	0.0445
Mental health	75.4	54.57	(23.5)	65.79	(20.4)	0.0018
Energy value	64.0	43.97	(25.2)	50.52	(23.8)	0.0693
Pain perception	86.3	57.04	(29.4)	60.46	(28.2)	0.7200

*Note:* Normal values means no long-standing illness reported; Coulter and Wright, 1993.

## Discussion

The study emerged from the interests of one general practitioner, who set up the hypnosis clinic, and in a desire to provide evidence of its effectiveness, took an interest in research and recruited some researchers to achieve those ends. The study is limited in that it was not controlled.

The study charts a very similar morbidity rating for patients referred to this hypnosis clinic compared with a report of psychiatric outpatients (Adler, Bungay, Cynn and Kosinski, 2000: Table 3). Our outcomes show that there are very marked effects on the SF-36 in the mental health group, moderate effects in the treatment of medical disorders, and no effects on smoking cessation. Hypnosis is usually regarded by hypnotists and the public as a particularly effective treatment for smoking, but the 10% quitting rate at one year was no better than other medical interventions (nicotine replacement or SSRIs). This was an NHS clinic, and most hypnosis studies have been carried out on private patients. A similar study recruiting from state funded sources (pregnant women) showed no significant effect from hypnosis intervention and the same overall quitting rate of 10% (Valbo and Fide, 1996).

**Table 3.** Comparing the study (Coulter, 1993: normative; Adler et al., 2000: elective surgery and outpatient psychiatric) results with our (AD) subgroups: smokers and mental health at point of entry to the evaluation

	Normative n = 6301	Elective surgery n = 2698	Outpatient psychiatric n = 411	AD mental health n = 44	AD smokers n = 46
Physical function	84.2	69.3	76.1	82.7	70.1
Physical role	80.9	55.6	55.9	55.8	60.4
Emotional role	81.3	72.9	38.9	36.4	57.9
Societal role	83.3	73	53.1	56.1	66.7
Mental health	74.7	70.6	45.7	48.9	57.5
Energy	60.9	54.2	38.8	43.9	46.1
Pain	75.2	61.0	66.9	67.1	64.8

This study noted a 31 point improvement in SF-36 'emotional role' in mental health patients 6 weeks post treatment. This compares favourably with a BMJ study into depressed patients receiving 'enhanced care' (antidepressants and psychotherapy with managed follow-up) which showed a 26 point improvement in emotional role 6 months after initiation of treatment. Whilst the study is limited, the effect of the intervention on the mental health group (comparative to the smoking group) is promising. The levels of continued use of hypnosis and its enabling effects are impressive. The results obtained from this initial piece of research warrant further study in the form of a controlled study of its relative benefit in general practice.

## Conclusion

This study suggests that referrals to a hypnosis clinic in general practice show a similar morbidity to referrals to a psychiatric outpatient clinic and fall into the category of 'high probability of clinical depression or other psychiatric disorder' (Adler et al., 2000: 346). The results indicate that hypnosis may be an effective treatment for mental health

conditions. Hypnosis may be a means of promoting mental health and further controlled study of its relative benefit in general practice should be undertaken.

## **Note**

The treatment manual for this study is available by email.

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