La Revue de l'hypnose et de la santé
Numéro 22, pp. 59-66
Utilisation des Croyances du Patient

Conversational Hypnosis is Beyond Belief and Completely Unexpected

By Dan Short

While physicians care for the physical body, therapists care for human consciousness, which requires intervention into what one perceives as real and helps one feel able to exercise choice (Short, 2021b). Ordinary conversation rarely reaches such depths. What we know from research in cognitive psychology is that abstract information does not change expectations or judgement, unless it is presented as a compelling narrative (Borgida & Nisbett, 1977), as practiced in conversational hypnosis. For subjective reality to evolve, the story must offer something unexpected. To understand what this means for therapy, we must know the difference between beliefs and expectancies.

A belief can be defined as a collection of propositions, expressed in language, that one considers to be true or that one *needs to be true*. While beliefs get their start in reasoned cognition, they remain influential even when held in long-term storage as a semantic memory. While in storage, a given belief remains undisturbed, until it is summoned for conscious review and exposed to critical thinking.

In contrast to belief, expectancy is the product of tacit learning that is mostly associational and usually expressed through the body (e.g., the chemotherapy patient who begins to vomit at the sight of the treatment facility). Expectancies operate as arational feeling states, until expressed in language (insight) at which point they may or may not become incorporated into belief. The practical difference is that while belief governs volitional behavior (in the form of conscious intent) preverbal expectancies govern non-volitional behavior and the autonomic nervous system (Kirsch, 1990).

Most importantly, beliefs foretell outcomes. When a belief is accurate, it enables people to make wise decisions and strategic predictions. To implement these belief-based choices, we rely on expectancies that mediate complex chains of habitual action (such as walking, talking, dressing, driving). This automaticity spares us from having to make millions of conscious choices throughout the day. Yet, expectancy effects are potentially independent, and always qualitatively different, from conscious belief. For example, think of the bride who fully intends to marry yet after walking towards the groom in a marriage ceremony she begins to cry and then runs out of the room. This response will be difficult for her to explain if her belief (he is the one) does not match her unexplored expectations (of a disastrous

marriage). Whereas beliefs lend themselves to conscious review, preverbal expectancies must be inferred through behavior.

Another key function of beliefs is that they solidify identity through a process of communicating intent ("I did that because …"). When a unique belief system is shared within a group, it fosters belonging and emotional resonance within the group ("we know the truth"). In its extreme form, group beliefs manifest as indoctrination or brainwashing, powerfully influencing who is trusted and what is perceived as meaningful. The more emotional benefit derived from a belief, the more likely one is to only focus on those things that confirm the belief, rather than considering contradictory evidence. Thus, compelling beliefs create self-sustaining ecosystems. This detachment can result in what outside observers perceive as superstition, rationalization, denial, or delusion.

Before applying these two concepts to clinical practice, it is helpful to recognize that language is best suited for addressing beliefs, while unstated expectancies are shaped by the experiential context. While mainstream talk therapy focuses on mediating belief, experiential therapies, such as hypnosis, focus on lived experience (either in virtual form or as a therapeutic directive). What follows is four general rules, each designed to address both sides of a dual process: what the therapist says and what the therapist does. Each rule begins with words "ask" or "discuss" (what the therapist says) followed by a description of what the therapist does: 1) join, 2) utilize, 3) defend, and 4) strengthen. As we will see, these two skill-sets merge seamlessly within conversational hypnosis.

1. Ask about the client's most important beliefs – Join as an ally

Unlike philosophers, whose job is to debate truth and challenge existing belief systems, the task of a therapist is to work in service of the patient's stated reasons for consenting to therapy. Just as a surgeon would never refuse care due to the patient's beliefs, all therapists have an ethical duty to serve the client's needs by supporting improved emotional, behavioral, or social functioning irrespective of ideological positions. In a clinical setting, differences in belief often include ideas that seem paranoid, delusional, grandiose, or otherwise detached from reality. Where the therapeutic posture of unconditional acceptance becomes tricky is when the patient has strong beliefs that the treatment you offer is of no value, or even worse, that you have done harm.

For example, a returning patient entered my office angrily stating, "I believe your comments to me at my first visit were wrong and shitty! I apologize for using that type of language, but it takes a lot of courage for me to be here and for you to tell me to 'stop murmuring' is unforgiveable! I have worked hard as a Latina woman to find my voice." Her full lecture was too long to quote here. Essentially, she believed that her trust had been sorely violated. Even though I had no memory of saying such a thing,

my task was not to argue about truth but rather to create the experience of safety—something she had fearfully requested at the start of therapy.

Speaking as her ally, I replied, "That is a horrible thing to have someone say to you. I am so glad you found the courage to confront me. This is important. You are being assertive. This is exactly what needs to happen for you to succeed in therapy!"

After blushing, and switching to a coy tone of voice, she responded, "Oh…Doctor Short, with you it is easy [to be assertive]." After a few minutes of reflection, she added, "Now that I think about it, you don't normally use derogatory language. … It may not even be you that said that … it was my mother who always told me to stop murmuring."

As with all instances of conversational hypnosis, it was not my words that mattered most but rather the shock or confusion of being met with support when she expected animosity. Thus, it was not what I said but what I did that altered her unconscious expectancies, which then reorganized her episodic memory, and subsequently her belief about the truth of her first visit to my office.

Beliefs that put the client at odds with the therapist are difficult to utilize.[1] But that does not mean that the belief lacks value. Everything that makes up an individual has value, this includes existing beliefs, attitudes, and expectancies. Beliefs can be thought of as a doorway offering access to a person's core values and most impactful life experiences. Rather than seeking to discredit a person's beliefs, it is better to identify major life events that need to be scrutinized. For example, the therapist might ask, "What led you to believe this? When did you first start to feel strongly about this belief?" If you join the client's cause as an ally, an expectation of safety is established. Due to associational learning, your office starts to feel like a sanctuary – a place where anything can be discussed.

2. Discuss points of agreement – Utilize shared ideas

Beliefs can be difficult to change. Often, people will passionately defend their beliefs even after being presented with disconfirming evidence. This normal behavior is known as belief perseverance. It is how individuals maintain a stable sense of reality. Beliefs that are shared within a group have even more power. Shared belief systems help people define who they are and how they should relate to others. When these beliefs are attacked, it threatens the individual's sense of belonging and connection to significant others. Thus, beliefs must be handled with care and respect.

For the sake of rapport, some might argue that it is better to ignore differences in belief and simply act as if you agree with everything the patient has to say. However, respect can never be

[1] In the clinical setting, utilization is defined as *the identification of elements already established within a system that can be applied to some useful end*.

achieved through lying. If you do not agree with another person's beliefs, you should not pretend that you do. Fortunately, you do not need to agree with every part of the patient's beliefs to utilize some aspect of their ideology.

As originally argued by William James, new truths must grow from a well-established belief (Short, 2021a). Therefore, in therapy it is important to discuss points of agreement and then utilize ideas that fit what you understand to be true. For example, if a patient tells me that his girlfriend intentionally made him angry, and therefore it is her fault that he hit her, my first task is to find an existing belief we both consider important. I was speaking to such a person who initially complained about the justice system and about being a marginalized minority member suffering from white oppression. My question was, "Do you believe that oppression through force is wrong? If so, let's talk about what makes it bad." This question was not used to cast him as a violent oppressor but rather to move the conversation over to a place of mutual agreement (this person later became a vocal advocate of nonviolent relationships). If your actions go beyond speaking the language of the patient, by actively utilizing goals that belong to the patient's ecology of belief, then an expectation of success ("I can do this!") automatically combines with the motivation to act ("This is what I want!").

3. Ask about progress – Defend the client's personal values

It is common for a patient to enter therapy with specific beliefs about what the problem is and how impossible it is to solve. In these types of discussions, the patient controls all the evidence and often arrives at extreme positions through confirmatory bias (only perceives those things that support the existing belief). For example, at the start of the school year, I counseled a mother and father on how to help their teenage son. At the time, he had failing grades, spent all his time playing video games, and in addition to doing nothing to help around the house, he took all his meals to his bedroom rather than eating at the table with the family. The parents had never established rules for the family, nor had they set any conditions for receiving the privileges he was given. I showed the parents how to do this and asked them to return in three months. When they returned, I asked if they did their part and they assured me that they had. However, in their view, none of it worked. They maintained their initial belief, stating, "Our son is a disappointment and there is nothing we can do about it."

Curiously, I asked, "What about his grades? Have they not improved?" The father confessed that the grades were higher, all B's and C's at this point. Next, I asked the mother, "Is he still not eating with the family?" She replied, "Well, no. He eats with us every night. Just last night he helped me make dinner." Turning again to the father, I asked, "Is he still spending all of his time playing video games?" With a sudden look of surprise, the father replied, "Well, no. He and my father are working together to

build a fence around our property." Often, unquestioned beliefs can blind us to what is happening in front of our eyes. Whenever a therapist asks about progress, it simultaneously validates the patient's values and exposes change.

Often, I begin therapy by defending clients' values and then review their actions. For example, I recently spoke with a man who spent the entire session complaining about his girlfriend's dishonest, manipulative, selfish, and destructive actions. He began his rant by acknowledging, "When I last saw you, a year ago, you predicted all of this. You warned me that if I got back together with her, she would break my heart again. And now, she is cheating on me with her ex-husband." For fifty-five minutes, I did nothing but listen to his criticism of her and affirm the goodness of the things he valued, such as honesty, kindness, and personal integrity. For example, I would interject, "You make a good point. Honesty is essential to healthy relationships."

When there was hardly any time left to talk, I told him, "There is a question you need to ask yourself—a very important one. Do not try to answer it in here. The question is, 'In what ways are you exactly like her?'" Before he got out the door, he had already confessed to three behaviors, "I lied to her, I stalked her, and I threatened her." Later that day, I received a text from him stating that he had identified eight more ways that he is just the same as her. In other words, I did not argue with his belief that he was a victim. Instead, I asked a single question that suddenly made him the subject of fifty-five minutes of his own critical review. Using this indirect approach, everything he said was utilized and a discussion of his potential for progress was initiated.

The utilization of belief sometimes requires the co-construction of a coherent autobiographical narrative and a consideration of the values that underlie one's motivation to strive for progress. For example, after hearing numerous, disjoined examples of troubled living, the therapist might ask, "When did this trouble start? What has been your method of coping? What made you decide to seek help? What outcome do you eventually wish to achieve?" These questions help build a coherent narrative and can then be paired with acknowledgement of the patient's core values. For example, "After hearing your story, it sounds like _____ really matters to you. Is that a core value of yours?" As shown in research, when asked about important values, people are less likely to respond defensively to information that challenges established beliefs (Crocker et al., 2008). Thus, when a therapist identifies and defends core values, the need for defense mechanisms (such as denial or rationalization) is greatly reduced.

4. Discuss areas of doubt – Strengthen critical thinking skills

As one of history's greatest teachers, Socrates recognized that all meaningful dialogue must begin in a place of certainty and then gradually progress to a state of inquiry (Socratic method). People

must utilize existing beliefs to think. But for intellectual growth to occur, one must eventually encounter a question that cannot be answered with the existing belief system. Returning to the wisdom of William James, we are cautioned to avoid creating disbelief in others. James reasoned that "disbelief" is an indication of conflict between beliefs rather than an open invitation for new truth. As James explains, "The true opposites of belief, psychologically considered, are doubt and inquiry, not disbelief" (Quoted in Short, 2021a). In other words, the experiences of doubt and inquiry lead us to expand our "truths" in an adaptive way.

In today's terminology, this process is referred to as critical thinking. It is the suggestion that, "You are able to reflect on what you choose to believe." Presupposing this possibility, the therapist might ask, "Are you willing to examine this belief? Have you ever stopped to scrutinize the evidence?" All critical thinking begins with a willingness to temporarily detach from a compelling idea and question its validity.

If the patient is open to inquiry, it is helpful to establish a line of demarcation between what is mostly likely true and what might be false. We can also introduce the use of confidence intervals. For example, while speaking with a patient who had become seriously delusional, I asked, "How real does this belief seem? Is it in the 0-30% range or is it in the 75-100% range?" The belief was that her husband and I were conspiring to harm her. She said it was at the lower end. Next, I asked, "What seems most likely true to you?" Her reply was, "That you are both trying to help me and that I REALLY need help." Rather than seeking to discredit her original belief, I strengthened her critical thinking skills.

Final Reflections

In clinical practice, the use of sound reason is important – but not sufficient. When seeking to influence reality-orientation and choice, it is necessary to create the experience of safety, an expectation of success, a grounding in personal values, and a capacity to question existing beliefs. This is one thing that sets conversational hypnosis apart from ordinary talk therapy – it simultaneously addresses those beliefs upon which conscious reality is constructed as well as unconscious expectancies that govern most day-to-day behavior. Those who utilize hypnotic methodology appreciate the unfathomable complexity of subjective realities that extend symbolically into unconscious domains. With this approach, conversations develop as metaphorical explorations into ideas enriched by feelings and episodic memories. Most of all, differences in thought are respected, conceptual pluralism is encouraged, and all conversations are designed to empower those seeking help.

References

Borgida, E., & Nisbett, R. E. (1977). The Differential Impact of Abstract vs. Concrete Information on Decisions1. *Journal of Applied Social Psychology*, *7*(3), 258–271. https://doi.org/10.1111/j.1559-1816.1977.tb00750.x

Crocker, J., Niiya, Y., & Mischkowski, D. (2008). Why Does Writing About Important Values Reduce Defensiveness? Self-Affirmation and the Role of Positive Other-Directed Feelings. *Psychological Science*, *19*, 740–747. https://doi.org/10.1111/j.1467-9280.2008.02150.x

Kirsch, I. (1990). *Changing expectations: A key to effective psychotherapy* (pp. xviii, 231). Thomson Brooks/Cole Publishing Co.

Short, D. (2021a). *De William James à Milton Erikson—Prendre soin de la conscience humaine*. SATAS. https://www.satas.com/en/hypnosis-brief-therapies-psychology/6924-de-william-james-a-milton-erikson-prendre-soin-de-la-conscience-humaine-9782872932290.html

Short, D. (2021b). *Making Psychotherapy More Effective with Unconscious Process Work*. Routledge. https://doi.org/10.4324/9781003127208