

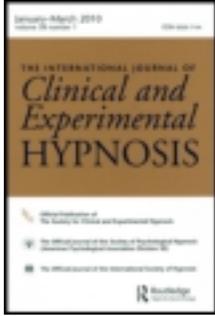
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Hypnosis as an empirically supported clinical intervention: The state of the evidence and a look to the future

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HYPNOSIS AS AN EMPIRICALLY
SUPPORTED CLINICAL INTERVENTION:
*The State of the Evidence
and a Look to the Future*

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Abstract: Drawing on the literature reviews of this special issue of the *International Journal of Clinical and Experimental Hypnosis* (2000), this article summarizes the evidence for the effectiveness of hypnosis as an empirically supported clinical intervention. As a whole, the clinical research to date generally substantiates the claim that hypnotic procedures can ameliorate some psychological and medical conditions, as judged against the Chambless and Hollon methodological guidelines. In many cases, these clinical procedures can also be quite cost-effective. It is probable that with some key empirical refinement a number of other hypnosis treatment protocols will have sufficient empirical documentation to be considered "well-established." However, it is noted that the Chambless and Hollon guidelines are not particularly well-suited for assessing hypnosis' impact when used adjunctly with other interventions. The article concludes with recommendations regarding the efficacy questions that need to be more fully addressed empirically and offers methodological guidelines for researchers and practitioners.

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Hypnosis has a rich and venerable history as a treatment in itself and as an adjunct to a variety of psychotherapeutic and medical procedures (Gauld, 1996). This special issue reveals that hypnotic procedures have received a great deal of empirical attention in many areas, comparable to, if not exceeding, the attention lavished on some of the most rigorously researched psychotherapies. Even a cursory reading of the articles in this special issue would impress most readers with the value of hypnosis as a psychotherapeutic procedure. Although a number of hypnotic procedures have not, as yet, earned a place among the few therapies that have met the platinum standard for well-established procedures of the rigorous criteria delineated by Chambless and Hollon (1998), it is, nevertheless, apparent that cost-effective hypnotic procedures can ameliorate an array of psychological and medical conditions. Indeed, it is evident that hypnosis is well positioned to thrive in a managed-care environment (Ballen & Jarratt, 1997). We hope that this article, which celebrates, as it were, the success of clinical hypnosis and which advances a research agenda for less-studied areas of clinical practice, will stimulate the research needed to convince even the most die-hard skeptics of the value of hypnotic procedures.

To place our review of the state of the evidence in perspective, it is necessary to describe the criteria for evaluating the empirical status of therapies, as delineated by Chambless and Hollon (1998) and described in Green and Lynn's article in this issue (2000). It must be emphasized that these standards are among the most rigorous of any that have been promulgated to date, and that the failure of a particular study to satisfy all of the standards by no means indicates that the treatment under study is ineffective.

Chambless and Hollon (1998) argue that to meet the least stringent criteria of a "possibly efficacious treatment," it is required that at least one study show that the treatment is superior to a no-treatment control, placebo group, or alternate treatment, or that the treatment in question matches the effectiveness of an alternative treatment of established efficacy.

To meet these current notions regarding criteria of an "efficacious treatment," the above criteria must be fulfilled with the additional stipulation that two studies, rather than one, must be demonstrably effective in two independent research settings, with no well-controlled research providing contradictory evidence. In addition, to fulfill the most stringent criteria of "efficacious and specific," the treatment must be shown to be superior to pill or psychological placebo or an alternative established treatment in at least two independent research settings.

A number of methodological criteria are also recommended by Chambless and Hollon (1998). That is, the studies must be conducted in the context of a randomized controlled trial and must adequately

describe the treatment procedures (i.e., preferably a treatment manual), employ valid and reliable outcome measures, and specify patient inclusion criteria in a reliable, valid manner. Chambless and Hollon recommend a sample size of 25 to 30 per condition in controlled (nonsingle-case) studies to ensure adequate statistical power. However, the authors also note that controlled single-case experiments or equivalent time-series designs are acceptable with as few as three participants. Accordingly, clinicians with relatively small caseloads can make substantial contributions to the literature on the clinical effectiveness of hypnotic interventions.

It is worth noting that guidelines for evaluating the empirical support of psychotherapy are not cast in stone and have, already, shown considerable evolution since their inception in response to thoughtful criticism and analysis. In fact, the question of how to assess therapy outcome is controversial and has received attention from government institutions, managed-care organizations, and traditional scientific organizations (see Andrews, 1995; Seligman, 1995; Strupp, Horowitz, & Lambert, 1997).

The guidelines in vogue today do not necessarily lend themselves to certain issues specific to hypnosis. For example, Barabasz and Barabasz (1992) explain how hypnosis can produce significant findings with relatively small samples, particularly when within-subjects comparisons and stringent controls for hypnotic suggestibility are used. Hence, the recommendations that are presented later in this article, following a summary of the evidence, are designed to move the field of hypnosis forward, rather than to slavishly adhere to any set of currently in vogue guidelines as the final word in the evaluation of treatment efficacy.

A SUMMARY OF THE EVIDENCE

Hypnotically induced analgesia. Arguably, the property of hypnosis that has the greatest potential for social good resides in the ability of participants to radically reduce, or in some cases eliminate, both chronic and acute pain. Indeed, a 1996 National Institute of Health Technology Assessment Panel Report judged hypnosis to be a viable and effective intervention for alleviating pain with cancer and other chronic pain conditions. This, in addition to a voluminous clinical literature and an increasingly robust research literature, leaves no doubt that patients undergoing burn wound debridement, or children enduring bone marrow aspirations, or mothers in the delivery room can sometimes achieve a dramatic reduction in pain with hypnosis. In some cases, the degree of analgesia matches or exceeds that derived from morphine, and hypnosis has served as sole anesthetic in surgery in thousands of documented cases.

Accordingly, it is not surprising that Montgomery, DuHamel, and Redd's meta-analytic review (2000 [this issue]) concludes that

hypnotically suggested pain reduction can be classified as a well-established treatment. Meta-analysis is a powerful statistical technique that provides a cumulative analysis of research findings in a given area by calculating effect sizes (an estimate of the magnitude of an intervention effect) across studies. This permits a direct comparison of treatment outcomes that span diverse methodological approaches and interventions.

Montgomery et al.'s review (2000) of 18 articles and 27 effect sizes, based on the pain reports of 933 participants, revealed that hypnotic suggestions relieve pain for 75% of the population, across different types of experienced pain. Equally encouraging is the finding that the magnitude of the hypnoanalgesic effect was comparable for clinical and healthy volunteer samples, and that individuals who scored in the midrange of hypnotic suggestibility—the majority of the population—responded comparably in terms of effect size to persons who scored in the high range of hypnotic suggestibility.

Although it is necessary to more closely examine the effects of hypnosis in acute versus chronic pain conditions and the role of dissociation and other individual difference variables in moderating treatment gains, the available evidence implies that hypnotic analgesia has a wide range of application. In fact, the findings reviewed were so positive that Montgomery et al. recommended expanding hypnotic procedures to a wider clientele and broaching hypnotically suggested analgesia with patients as a viable treatment modality. The fact that hypnosis can now be considered a well-established treatment for pain should go a long way to ensure that hypnotic interventions move into the mainstream of first-line interventions for pain-related disorders and conditions.

Hypnosis in medicine. From antiquity to the present time (Gauld, 1996), hypnosis and hypnotic-like procedures have had a role in medicine. Over the years, a steady stream of case reports and anecdotal observations has spurred interest in the healing effects of hypnotic procedures. Yet, it was not until the 1980s that well-controlled studies systematically evaluated the role of hypnosis in the treatment of medical conditions and began to provide convincing evidence for the efficacy of hypnosis-based interventions.

Pinnell and Covino's panoramic review (2000 [this issue]) of hypnosis in medicine indicates that reasonably well-controlled studies with carefully selected patients support the use of hypnosis in the preoperative preparation of surgical patients (Blankfield, 1991; Enqvist, von Konow, & Bystedt, 1995; S. A. Lambert, 1996; Lang, Joyce, Spiegel, Hamilton, & Lee, 1996), the treatment of a subgroup of patients with asthma (Ewer & Stewart, 1986), and the treatment of patients with dermatological disorders (Spanos, Stenstrom, & Johnston, 1988; Spanos, Williams, & Gwynn, 1990; Zachariae, Øster, Bjerring, & Kragballe, 1996), irritable bowel syndrome (Harvey, Hinton, Gunary, & Barry, 1989; Whorwell, Prior, &

Faragher, 1984; Whorwell, Prior, & Colgan, 1987), hemophilia (Swirsky-Sacchetti & Margolis, 1986), and postchemotherapy nausea and emesis (Lyles, Burish, Krozely, & Oldham, 1982; Zeltzer, Dolgin, LeBaron, & LeBaron, 1991). There are strong indications that hypnosis is helpful in the treatment of these diverse conditions, strengthening confidence in the possibility that larger studies with fully elaborated procedures will ultimately satisfy the criteria for empirical support for hypnotic interventions in these areas.

Hypnosis and smoking cessation. The literature on hypnosis and smoking cessation indicates that hypnotic interventions, by promoting abstinence, can prevent smoking-related illnesses. Based on their review of 59 studies, Green and Lynn (2000 [this issue]) noted that hypnotic interventions generally yield higher rates of abstinence relative to wait-list and no-treatment conditions. Whereas hypnotic procedures are not necessarily more effective than alternative treatments, and the evidence for whether hypnosis yields outcomes superior to placebos is mixed, hypnotic procedures are very cost-effective and have earned a place among entry-level treatments in stepped-care approaches that begin with the least costly and time-consuming interventions.

Studies designed to demonstrate the specificity of hypnotic procedures and move hypnosis into the arena of empirically supported treatments should endeavor to include biochemical measures of abstinence and should establish whether the addition of hypnosis enhances the effects of the cognitive-behavioral and educational interventions with which it is coupled.

Clinical hypnosis with children. Hypnosis has seen a wide range of application with children, spanning the treatment of learning problems, acute pain, basic physiological processes, general medical problems, and nausea and emesis from chemotherapy. The lion's share of the 15 studies that Milling and Costantino (2000 [this issue]) review focus on the relief of chemotherapy distress and acute pain. Although the authors note that research on hypnosis with children is in a relatively early stage of development, one study by Edwards and van der Spuy (1985) of clinical hypnosis for nocturnally enuretic children has already fulfilled the criteria for a *possibly efficacious treatment*. Other promising studies reviewed include research on imagination-focused hypnosis for nausea and vomiting related to chemotherapy (Zeltzer et al., 1991), pain from bone marrow aspirations and lumbar punctures (Zeltzer & LeBaron, 1982), and pain reduction in hypnotically suggestible children undergoing venipuncture and bone marrow aspirations (Smith, Barabasz, & Barabasz, 1996). Future researchers could well build on these encouraging findings by formalizing the description of the procedures implemented and examining treatment and patient variables theoretically related to successful outcome.

Cognitive-behavioral treatments. Early reviews of the research literature suggested that disorders involving “self-initiated” difficulties, especially those that impair concentration, such as alcoholism and drug abuse, were fairly resistant to hypnosis. However, disorders involving a substantial “nonvolitional” component (pain disorders, asthma, skin disorders) were indeed responsive. In reality though, the cohort of first-rate empirical work at that time was just not large enough to make refined distinctions about differential effects across specific disorders. Later, Kirsch and his colleagues (Kirsch, Montgomery, & Sapirstein, 1995) conducted a more broad-spectrum meta-analysis of empirical studies that had compared the effectiveness of cognitive-behavioral treatments (CBT) with and without hypnosis across a number of disorders (e.g., obesity, insomnia, anxiety, pain, and hypertension). The findings were instructive. First, there was a substantial effect size for CBT with hypnosis, when compared to the same treatments without hypnosis. Patients receiving CBT with hypnosis showed greater improvement than at least 70% of patients who received standard CBT. Second, mere relaxation did not appear to be the mechanism. Third, there was a hint that the advantages of adding hypnosis to CBT might increase over time, though this was not definitive. After publication of these findings, hypnosis as an adjunct procedure for the treatment of obesity was cited as “probably” empirically validated by a task force of the American Psychological Association.

Schoenberger’s review (2000 [this issue]) provides further substantiation of the value of hypnotic interventions insofar as hypnotic treatments, combined with cognitive-behavioral methods, generally produce outcomes superior to wait-list and no-treatment control conditions. Although no hypnotically augmented cognitive-behavioral treatment has as yet met the criteria for a well-established treatment, especially promising treatment gains have been observed in relation to obesity, anxiety disorders, and pain management. Given that many cognitive-behavioral procedures can easily be conducted with hypnosis or simply relabeled as “hypnosis,” it seems that behaviorally oriented clinicians with training in hypnosis could readily establish a hypnotic context as a simple, cost-effective means of enhancing treatment efficacy.

Treatment of trauma. It is virtually impossible to locate a compendium of chapters or articles on clinical hypnosis that does not contain material touting the value of hypnosis in the treatment of posttraumatic reactions. An abundance of anecdotal reports and case studies laud hypnosis as an effective treatment of the repercussions of trauma. However, Cardeña’s review (2000 [this issue]) found only one study (Brom, Kleber, & Defare, 1989) on this topic that approaches fulfilling the Chambless and Hollon (1998) criteria. More research in this area is urgently needed, given the fact that people with posttraumatic stress disorder (PTSD)

have been shown to be highly hypnotizable (D. Spiegel, Hunt, & Dondershine, 1988; Stutman & Bliss, 1985) and, therefore, may be particularly amenable to hypnotic interventions.

It would be useful, for example, to compare exposure therapies with and without hypnosis. In such studies, hypnosis could be used to enhance visual imagery during flooding, for example, and to have a calming influence on patients after anxiety-eliciting procedures are implemented. The nature and severity of trauma (e.g., immediately experienced versus witnessed; physical injury versus no injury), whether the traumatic event was in the recent or remote past, and the intensity of posttraumatic and dissociative symptoms may be important variables to consider in research on the use of hypnosis in the treatment of posttraumatic reactions.

For hypnosis to achieve the coveted status of a well-established procedure in this and other treatment areas, only a few well-controlled studies are needed that either (a) document the value of hypnotic procedures compared with already established empirically supported techniques, or (b) show that hypnotic interventions are superior to placebo control. In conducting such investigations, researchers can remedy past design and reporting deficits and sidestep the pitfalls encountered by previous researchers by heeding the recommendations in the following section (for related discussions, see Barabasz & Barabasz, 1992; Fromm, 1981).

RECOMMENDATIONS

Reporting Considerations

1. *Define the population carefully.* Description of the population is necessary to gauge the representativeness of the sample chosen, to replicate or extend previous findings in meaningful ways, and to evaluate the potential specificity versus generalizability of the treatment gains to diverse populations. To this end, researchers should identify the diagnostic procedures used to categorize the patient sample as well as report the patient's age, treatment history, medications taken, duration of the disorder or condition, comorbid diagnoses, tests administered, and demographic information to determine potential mediators and moderators of treatment effects.

2. *Report the procedures in sufficient detail to permit replication.* Failure to describe the parameters of an intervention studied hinders evaluation of the procedures employed and precludes replication and extension of the treatment under study. Understandably, treatment manuals that specify the nature and sequence of procedures implemented or, alternately, procedural descriptions that consist of session-by-session outlines of interventions or delineation of broad principles and phases of treatment with examples of interventions are required for a particular treatment to be considered empirically supported.

These requirements provide a reasonably elastic standard for the specification of treatment procedures insofar as they can accommodate a variety of hypnotic interventions, including ones that involve substantial customizing of suggestions to patient characteristics, as might be the case in the treatment of someone with PTSD, for example (see Watkins & Watkins, 1997, for an example of a well-documented yet individually tailored approach). Indeed, we recognize that one of the advantages of hypnotic interventions is that they are flexible and individually tailored to the needs of patients. Accordingly, it is important to approach the ideal of conducting ecologically valid treatment studies that have fidelity to the way hypnosis is often practiced in the "real world," while providing detailed and accurate descriptions of research protocols in treatment studies.

In terms of the studies reviewed in this issue, procedures were often reported in detail insufficient to determine whether the intervention could be considered a manualized or replicable approach to treatment. Standardized hypnotic suggestibility scales, which follow a specified protocol, while widely used for laboratory research purposes, were rarely used for purposes of induction in the studies reviewed. More commonly, idiosyncratic suggestions were employed that were specific to the treatment implemented. These procedures were often described in vague terms, such as "ego-strengthening suggestions" and "guided imagery," that encompass a broad range of interventions. Exemplary suggestions were not provided, nor were broad principles of treatment articulated. Clearly, this is an area in which considerable progress can be made in future studies.

3. *Clearly indicate whether participants were randomly assigned to treatments.* Not infrequently, studies cited in this issue failed to specify whether participants were randomly assigned to treatments, and it was necessary to glean this information from descriptions of the sampling procedures. In some cases, this was difficult, and in other cases, impossible to do so from the information provided. In still other cases, assignment to treatment was initially carried out on a random basis; however, random assignment was ultimately precluded by participant selection factors, such as medical problems or limitations, that made it impossible for individuals to participate in a particular treatment, such as rapid smoking to facilitate smoking cessation. Individuals who were not able to participate in rapid smoking treatment because of hypertension, for example, were, by default, assigned to the non-rapid-smoking group, compromising the randomization of the procedures. When randomization is incomplete, the rationale ought to be clearly indicated, and the implications vis-à-vis the issue of empirical support discussed.

4. *Report hypnotic suggestibility of the samples.* Whereas randomization is a laudable goal in most studies, in hypnosis research it does carry a risk

that disproportionate numbers of extremely high or low hypnotizable persons in between-groups studies will skew treatment effects. That is, random assignment of patients to hypnosis or nonhypnosis groups can erroneously produce statistical significance (Type 1 or alpha error) by the chance occurrence of disproportionate numbers of extremely high or extremely low hypnotizable responders in either group. Accordingly, it is important to evaluate hypnotic suggestibility across groups and to consider matching or stratifying the sample in question on the basis of hypnotic suggestibility across hypnotic and nonhypnotic groups. At the very least, researchers should fully report the hypnotic suggestibility of each group in terms of scores on well-validated scales and use these scores as covariates in statistical analyses when groups differ in terms of this variable.

5. *Report complete descriptive data.* Not infrequently, the studies reviewed failed to provide a complete report of the data secured. The inclusion of pretreatment and posttreatment means and standard deviations by experimental condition is essential to the conduct of meta-analytic techniques (Milling & Costantino, 2000). In addition to mean differences, researchers should report effect sizes to document the magnitude of treatment effects obtained across conditions.

Finally, differential dropout rates across treatments should be reported, and a logical, consistent approach to handling the problem of dropouts or missing data should be articulated. For example, in the smoking cessation literature, it is now considered appropriate to conduct analyses in which dropouts are considered as treatment failures.

Design Considerations

1. *Ensure that the number of participants is adequate.* The claim that a particular finding is generalizable to a relevant population of individuals is often less than compelling when the sample size is small. Of course, a small sample also limits the statistical power necessary to discern treatment effects when they are, in fact, present. The minimum number of 25 to 30 participants per condition recommended by Chambless and Hollon (1998) seems like a serviceable goal for many studies, particularly those intended to generalize findings to large populations, such as smokers in the general population. However, significant effects shown with relatively small samples may well be clinically meaningful and constitute important demonstrations of treatment efficacy. Therefore, it would be a mistake to dismiss studies that demonstrated significant effects with small samples.

One way that the inclusion of small samples can be justified is by conducting a power analysis. A general understanding of what is involved in statistical power analysis can be far reaching, because it can help avoid potentially irrevocable investigation-planning errors. The investigator

will have an estimate of how many patients to study and will know what kind of data to collect for a major hypothesis-testing study. The process also discourages the all too common treatment efficacy research practice of post hoc analyses, which might most charitably be viewed as fishing expeditions with a variety of statistical tests as hooks.

However, it is important not to ignore data collection opportunities with small numbers of patients. Power calculation can become particularly inaccurate for the sample cell sizes available in most clinical and hospital settings. Clinicians should not be discouraged from conducting research because of the large numbers of patients predicted to be necessary by power analysis. For example, despite a total number of 20 patients and cell sizes of only 5 patients per group, statistically significant reductions of both experimental and clinical pain were demonstrated for chronic pain patients independent of expectancy (Barabasz & Barabasz, 1989).

2. *Conduct single- or multiple-case experiments.* Whereas it can be argued that even greater confidence in the representativeness of the findings can be secured with relatively large samples, guidelines for empirically supported treatments include provisions for evaluating the efficacy of treatments based on single- or multiple-case experiments. Given that multiple replications of treatment efficacy with as few as 3 patients each by two independent research groups are required to establish empirical support for a given treatment, practicing clinicians can play an instrumental role in establishing a hypnotic treatment's effectiveness.

Case studies that compare individuals on a within-subjects, rather than a between-group, basis may have particular relevance for hypnosis studies. For example, Hilgard and Tart (1966) argued that the between-group approach may fail to show a true effect, even when one exists (a Type II or beta error). Their hypothesis is that patients who are high in hypnotic suggestibility can experience spontaneous hypnotic effects in response to suggestive interventions, even without a prior induction. Support for this contention was secured in three independent studies (see Barabasz, 1990, 1990a, 1990b; Barabasz & Barabasz, 1992) that imply that a within-subjects research design may be of critical importance if effects of hypnosis are to be detected. That is, the changes from nonhypnotic conditions to hypnosis for highly hypnotizable persons can easily be minimal or nonexistent. Whereas an ideal research program might combine within-subjects and between-group designs, with small as well as relatively large samples, much can be learned from scrupulously designed (e.g., adequate baseline and hypnotic suggestibility testing) single-case studies with as few as 3 participants.

3. *Compare nonhypnotic treatments with hypnotic inductions and suggestions added.* Rarely, if ever, is hypnosis the sole form of treatment with a patient: It is a technique, not a type of therapy. In fact, the position of the

Society for Clinical and Experimental Hypnosis is that hypnosis cannot and should not stand alone as the sole medical or psychological intervention for any disorder. Instead, hypnosis is used in addition to some recognized medical or psychological treatment protocol (e.g., cognitive-behavioral therapy, standard postsurgical procedures, psychoanalytic psychotherapy). For years now, hypnosis has been recognized as a legitimate component of medical treatment by the American Medical Association and the American Psychiatric Association. At issue, then, is not the effectiveness of some mythical hypnosis treatment, but whether hypnosis adds anything to the effectiveness of standard clinical interventions. Accordingly, additional studies comparing the same treatment with and without hypnosis (e.g., Schoenberger, Kirsch, Gearan, Montgomery, & Pastyrnak, 1997) would help to address the question of whether hypnosis augments treatment outcome, above and beyond the intervention within which it is embedded.

Another issue is that many different treatments are categorized as hypnosis, despite significant differences among them (Pinnell & Covino, 2000). For instance, in the studies reviewed, psychological treatments that included hypnotic interventions for medical conditions ranged from specific direct suggestions to control symptoms to complex suggestions for relaxation, guided imagery, and well-being. Conversely, the authors offered examples of instances when treatments that involved commonly used hypnotic techniques and suggestions were not defined as hypnosis. Under these conditions, the specific role of defining the situation as hypnosis versus the impact of suggestion-related effects is difficult to tease apart.

In selected cases, direct hypnotic suggestions may constitute an effective intervention in the absence of a more encompassing treatment. Whereas the relief of acute pain not accompanied by secondary gain or other noncomplicated symptoms, such as warts, may respond to direct hypnotic suggestions, more complex problems, such as chronic pain or depression, demand that hypnosis be conducted within the context of a more comprehensive therapy. An important task for researchers is to differentiate the effects of hypnosis when it is used as an intervention in itself as opposed to when it is used to facilitate a more comprehensive therapy.

4. *Conduct adequate follow-ups.* Follow-ups are essential insofar as there is no guarantee that treatment gains that are apparent at the end of treatment will be stable over time. The possibility exists that treatment effects degrade or improve across different conditions at different rates or disappear completely in one condition while they are only manifested later in another condition. For instance, in Bolocofsky, Spinler, and Coulthard-Morris's [1985] study, participants in a hypnosis condition for weight reduction continued to lose weight over the course of the

2-year follow-up period, whereas participants in the nonhypnotic treatment did not. It would be profitable for investigators to examine the following mechanisms of change that enhance versus delimit treatment effects during and after treatment.

Mechanisms

1. *Assess hypnotic suggestibility.* Individuals who exhibit relatively high hypnotic responsiveness, such as those diagnosed with bulimia (Pettinati, Home, & Staats, 1985) or PTSD (D. Spiegel, Hunt, & Dondershine, 1988; Stutman & Bliss, 1985), may be particularly good candidates for hypnotic treatments. Yet, this hypothesis has not been adequately tested. Treatment studies have not incorporated measures of hypnotic suggestibility on a systematic basis with respect to these and many other conditions. It can be argued that if hypnotic suggestibility is not associated with treatment outcome then hypnotic procedures have little bearing on any positive gains achieved. However, there are a number of reasons to believe that the hypnotic context could potentiate treatment gains, even though hypnotic suggestibility fails to moderate these gains.

Not all clients can benefit from hypnotic treatment (Wadden & Anderton, 1982; Brown & Fromm, 1987). Nevertheless, most of the interventions reviewed in this journal require little special hypnotic or imaginative abilities and, instead, rely on relatively easy suggestions (e.g., relaxation, guided imagery, imaginative rehearsal) that the majority of the population can successfully pass. Accordingly, it would not be expected that extreme hypnotic suggestibility would confer any particular advantage on a patient, or that relatively low levels of hypnotic responsiveness would preclude successfully responding to many therapeutic suggestions. In short, the reliance on relatively "easy" suggestions in a given treatment would be expected to attenuate correlations between measured hypnotic suggestibility—which entails assessment of a broad range of suggestions that vary in difficulty—and treatment outcome.

Relatedly, the relationship between the ability to achieve a suggested state of affairs and treatment outcome may vary from remote to strong. Relaxation suggestions for smoking cessation, for instance, may well promote mental and physical relaxation, yet such suggestions may not be sufficient to curb strong urges to smoke. Relatedly, relaxation suggestions incorporated in cognitive-behavioral treatments for anxiety may not be effective unless they promote exposure and eventual habituation/ extinction to anxiety-evoking stimuli. Not surprisingly, the evidence for a link between hypnotic responsiveness and smoking abstinence and the outcome of cognitive-behavioral therapies for anxiety is mixed. On the other hand, the ability to experience an analgesia suggestion is associated with both indices of pain relief and measured hyp-

notic suggestibility (Montgomery et al., 2000), observations understandable in terms of the correspondence between the experience of analgesia and the ability to alter cognitive-perceptual-sensory processes that typify the person who is highly responsive to hypnotic suggestion.

The link between hypnotic suggestibility and treatment outcome is potentially mediated by other factors, such as expectancies (Schoenberger, 2000). If hypnotic suggestibility is measured before treatment, then there can be a carryover of expectancies regarding hypnotic responsiveness to the treatment itself. Conversely, contamination by the perceived effects of treatment can occur when hypnotic suggestibility is assessed after treatment. In examining the literature on hypnosis in medicine, Pinnell and Covino (2000) noted that when hypnosis was assessed at a later time, after the conclusion of treatment, and in a context seemingly unrelated to treatment, hypnotic suggestibility was not associated with treatment gains. Clearly, expectancies and hypnotic suggestibility should be assessed in tandem, permitting an examination of the independent and interactive effects of these two variables on treatment outcome.

Researchers can use any number of hypnosis scales to provide a quantitative assessment of hypnotic suggestibility. Two sensible choices for a short yet informative multidimensional assessment are the Hypnotic Induction Profile (H. Spiegel & Spiegel, 1978) and the Stanford Hypnotic Clinical Scales (SHCS) of Morgan and Hilgard (1978-1979a, 1978-1979b), which offer measures for both adults and children in less than 15 minutes. Barabasz and Barabasz (1992), as well as Nadon and Laurence (1994), strongly recommended the much longer Stanford Hypnotic Susceptibility Scale, Form C (SHSS:C; Weitzenhoffer & Hilgard, 1962) or a tailored version (Hilgard, Crawford, Bowers, & Kihlstrom, 1979) "primarily because of its stringency and its broad sampling of hypnotic suggestions" (Nadon & Laurence, 1994, p. 91) that are potentially relevant to treatment. However, the SHSS:C frequently takes more than an hour to administer, thereby limiting its use in many clinical situations. The SHSS:C has more "top" due to the greater number and difficulty of items, making it essential for interventions that require high levels of hypnotic involvement (e.g., hypnosis as the sole anesthetic for surgical procedures for patients for whom general anesthesia is contraindicated).

2. *Assess expectancies.* Expectancies can account for a significant amount of variability in response to a variety of hypnotic and nonhypnotic interventions (Kirsch, 1990). One possibility is that treatment success varies as a function of the positive expectancies for treatment gains that the procedures engender. Accordingly, the relaxation or vivid imaginings evoked by suggestions contained in hypnotic protocols may pale in influence compared with the positive expectancies for treatment gains generated by the mere label of the procedures as "hypnotic" (Barber,

1985; Kirsch, 1990). In hypnotically augmented smoking cessation treatments, success may be contingent on the ability of hypnosis to catalyze positive expectancies and the motivation to quit, which seem to be prerequisite to the achievement of abstinence. The potentially powerful role that therapist as well as patient expectancies play implies that active as well as placebo treatments ought to be equated for treatment credibility. Furthermore, researchers should consider manipulating expectancies and demand characteristics to examine their influence (Barabasz & Barabasz, 1989). If that is impractical, expectancies ought to be assessed and their influence controlled by way of analysis of covariance of the results obtained.

3. *Assess motivation.* Motivation can be thought of as the commitment to fully comply with a given psychological treatment and participate fully in activities associated with the achievement of personal goals and durable treatment gains. Motivation can operate quite independently of positive expectancies for treatment gain. For instance, motivation and engagement in suggested activities may decrease in proportion to the belief that hypnosis has special healing qualities independent of personal effort. Accordingly, pretest as well as posttest measures of motivation, compliance, or adherence, and perceived achievement of treatment goals provide useful information above and beyond what can be gleaned from measures of expectancy alone.

4. *Consider measures of the interpersonal and dynamic aspects of engagement in treatment.* Assessment batteries often ignore measures that are relevant to psychological theories. For instance, we could locate no study among those reviewed that included measures pertinent to the therapeutic alliance with the hypnotist/therapist or that assessed mechanisms deemed relevant by psychodynamic theory to treatment outcome, such as psychological defenses. This is unfortunate insofar as patients who improve in psychotherapy often show changes in the degree of positivity in their relationship interactions with the therapist (Crits-Christoph & Luborsky, 1990) and in the maturity of their psychological defenses (Greynier & Luborsky, 1996).

In addition, future researchers should consider administering Nash and Spinler's (1989) measure of archaic involvement. This measure assesses dimensions thought to be relevant to the affectively laden, interpersonal dimension of hypnosis. The scale, which includes subscales that assess the dimensions of the perceived power of the hypnotist, the positive emotional bond with the hypnotist, and fear of negative appraisal, has been shown to be positively correlated ($r = .52$) with hypnotic suggestibility at posttreatment.

5. *Examine a variety of determinants of positive and negative treatment effects.* Study of the contraindications of hypnosis is warranted. To what

extent does minimal hypnotic suggestibility preclude embarking on a treatment that includes hypnosis? Are there any pathological conditions or personality characteristics that would disqualify an individual from participating in a hypnotic treatment? For instance, obsessive-compulsive patients have been shown to be less responsive to hypnotic suggestion than both other patient groups and normal controls (Spinhoven, Van Dyck, Hoogduin, & Schaap, 1991). Patients with little or no hypnotic ability may be better served with nonhypnotic treatments (Bates, 1993).

Measures of dissociation lend themselves to inclusion in treatment efficacy studies given the theoretical link between dissociation and hypnotic suggestibility (e.g., Hilgard, 1986). Recently, Barber (1999) has forwarded the intriguing hypothesis that individuals have distinct styles of responding to hypnotic suggestions, such that some individuals respond primarily in terms of situational demand characteristics, whereas perhaps a much smaller percentage of individuals become more imaginatively or dissociatively (e.g., experience spontaneous amnesia) involved with suggestions. Accordingly, measures of imagination and dissociation might help to select subgroups of patients who are particularly responsive to different treatment interventions. Relatedly, studies that examine the ability of measures of general and specific psychopathology to predict treatment outcome would substantially contribute to our knowledge base that now consists mostly of studies that examine openness to experience, absorption, and hypnotic suggestibility as predictors of responsiveness to treatment.

Outcome measures that assess these various domains and address the above questions can be costly and time-consuming to administer. Accordingly, their selection should be made with care and based on a variety of considerations, including the psychometric properties of available instruments, relevance to the target group, sensitivity to change and treatment effects, cost-effectiveness, and compatibility with the theoretical mechanisms posited to influence successful outcome (M. J. Lambert, Horowitz, & Strupp, 1997).

CONCLUSION

The evidence reviewed in this special issue affords much in the way of encouragement to practitioners who already use hypnotic techniques and to practitioners who wish to incorporate hypnotic procedures into their clinical repertoire. In fact, hypnosis fares well in comparison with the quantity and quality of research regarding many other psychotherapeutic endeavors. Although this special issue underscores the cost-effectiveness of hypnotic procedures and their utility in treating many conditions, it also underlines the need for continued evaluation and assessment of the empirical status of hypnotic interventions.

As noted by Nash (2000 [this issue]) in his preamble to this special issue, Ernest Hilgard predicted that as the scientific community continues to use hypnosis as a routine laboratory tool to examine human emotion and cognitive functioning, there will be a kind of laboratory spin-off to the clinical community. That is, there will be a process of domestication within the clinical sphere as well. This prediction has clearly been realized. However, even more important, the findings reviewed in this special issue document that clinical hypnosis is securely grounded in a foundation of careful empirical work that fully substantiates efficacy under certain circumstances. If the ethos and tone of the Report of the Royal Commission (Franklin, Majault, Le Roy, Sallin, Bailly, D'Arcet, De Borie, Guillotin, & Lavoisier, 1785) was our touchstone in producing this report, then indeed Franklin's and Lavoisier's notion of science as disciplined wonderment is as relevant now as it was 216 years ago. The harvest has been rich, but the field requires careful and inspired husbandry to yield yet more. Surely, our stern Age of Enlightenment progenitors would have it no other way.

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Hypnose als empirisch gestützte klinische Intervention: Gegenwärtige Situation und Blick auf die Zukunft

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Etsel Cardaña, und David Patterson

Zusammenfassung: Dieser Artikel stützt sich auf die Analysen der Fachliteratur in einem Sonderheft des *International Journal of Clinical and Experimental Hypnosis* (2000) und faßt die Nachweise zur Wirksamkeit von Hypnose als einer empirisch gestützten klinischen Intervention zusammen. Insgesamt erhärtet die gegenwärtige klinische Forschung im allgemeinen den Anspruch, daß hypnotische Behandlung auf einige psychische und physische Störungen besser einwirken kann, wobei die methodologischen Richtlinien von Chambless und Hollon zugrunde gelegt wurden. In vielen Fällen können diese klinischen Behandlungen durchaus kostengünstig sein. Es ist wahrscheinlich, daß bei zunehmender Verfeinerung empirischer Methoden und Weiterentwicklung von Schlüsseldaten eine Anzahl von weiteren Hypnose-Behandlungsprotokollen ausreichend empirisch gestützt werden, so daß sie als "fest etabliert" gelten können. Es wird jedoch festgestellt, daß die Richtlinien von Chambless und Hollon sich nicht besonders dafür eignen, den Impact von Hypnose als begleitende Behandlung zusammen mit anderen Interventionen zu bewerten. Der Artikel schließt mit Empfehlungen in bezug auf Fragen der Wirksamkeit, die gründlicher empirisch untersucht werden

müssen, und schlägt methodologische Richtlinien für Forscher und Therapeuten vor.

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**L'Hypnose comme intervention clinique empiriquement appuyée
par l'expérience: état de l'évidence et regard vers le futur**

**Steven Jay Lynn, Irving Kirsch, Arreed Barabasz,
Etzel Cardeña, et David Patterson**

Résumé: En dessinant les contours d'une revue de la littérature pour une édition spéciale du *Journal International d'Hypnose Clinique et Expérimentale* (2000), cet article récapitule l'évidente efficacité de l'hypnose comme une intervention clinique empiriquement proposée. Dans l'ensemble, la recherche clinique justifie généralement la réclamation que les procédures hypnotiques peuvent améliorer quelques états psychologiques et médicaux, bien que jugées de façon négative par les directives méthodologiques de Chambless et de Hollon. Dans beaucoup de cas, ces procédures cliniques peuvent également être tout à fait rentables. Il est probable qu'avec une certaine amélioration empirique un certain nombre d'autres protocoles de traitement d'hypnose auront suffisamment de documentation empirique pour être considérés comme "bien établis." Mais on note que les directives de Chambless et de Hollon ne sont pas particulièrement bien adaptées pour donner de l'impact à l'intervention hypnotique quand elle est adjointe à d'autres interventions. L'article se termine par des recommandations passant en revue les questions efficaces qui ont besoin d'être posées empiriquement et il offre des procédures méthodologiques aux chercheurs et praticiens.

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**La hipnosis como una intervención clínica con una base empírica:
La naturaleza de la evidencia y una mirada al futuro**

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Etzel Cardeña, y David Patterson**

Resumen: Basándonos en las revisiones de literatura de este número especial de la *International Journal of Clinical and Experimental Hypnosis* (2000), este artículo resume la evidencia de la eficacia de la hipnosis como una intervención clínica con una base empírica. En general, la investigación clínica hasta el momento concuerda con la aserción de que los procedimientos hipnóticos pueden mejorar algunas condiciones psicológicas y médicas, de acuerdo a las directivas metodológicas de Chambless y Hollon. En muchos casos, estos procedimientos clínicos pueden también ser bastante económicos. Es probable que con algunos refinamientos empíricos claves, otros protocolos de tratamiento hipnótico obtendrán suficiente documentación empírica para que se

les considere "bien establecidos." Pero señalamos también que los lineamientos de Chambless y Hollon no se ajustan muy bien a la evaluación del impacto de la hipnosis cuando se usa como adjunto de otras intervenciones. El artículo concluye con recomendaciones dirigidas a áreas de eficacia clínica que necesitan mayor atención empírica, y ofrece lineamientos metodológicos a investigadores y clínicos.

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