

Which Forms of Hypnotherapy are Evidence-Based?

Hypnotherapy as Empirically-Supported Treatment (EST)

Ratings using Chambless & Hollon (1998) criteria reviewed by David M. Wark (2008)

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I beg farther to remark, if my theory and pretensions, as to the nature, cause, and extent of the phenomena of [hypnotism] have none of the fascinations of the transcendental to captivate the lovers of the marvellous, the credulous and enthusiastic, which the pretensions and alleged occult agency of the mesmerists have, still I hope my views will not be the less acceptable to honest and sober-minded men, because they are all level to our comprehension, and reconcilable with well-known physiological and psychological principles.

– James Braid, *Hypnotic Therapeutics*, 1853

One of the most useful articles to be published recently was a review of those studies on hypnotherapy which were rated as meeting the Chambless & Hollon (1998) criteria for empirically-supported treatments in the field of psychology, known as ESTs for short. It may not surprise many NCH members to know that when the research literature on psychotherapy was previously reviewed by a task force of nineteen psychologists led by Prof. Dianne Chambless most of the psychological therapies identified as “empirically-supported” (formerly termed “empirically-validated”) tended to be specific forms of cognitive and/or behaviour therapy (CBT). Most forms of psychotherapy, ranging from the more controversial and pseudoscientific ones to some of the more “respectable” and mainstream approaches, do not meet these strict criteria for empirical support. However, one study was identified which demonstrated that cognitive-behavioural hypnotherapy (CBH) was “probably efficacious” for weight loss in obese clients. In this respect, hypnotherapy might (tentatively) be said to have garnered more compelling evidence for its efficacy than many other modalities of psychological therapy, apart from the cognitive and/or behavioural treatments and some brief psychodynamic approaches.

However, over the past decade, many additional studies of a high quality have been published which provide support for the efficacy of hypnotherapy, including meta-analyses and systematic reviews which collate data from multiple studies to form a more general picture of the research findings in this area. David Wark’s review entitled ‘What we can do with hypnosis: a brief note’ identifies over thirty additional studies on hypnotherapy which he rates using the revised Chambless & Hollon (1998) criteria for either “possible”, “probable”, or “specific” empirically-supported treatments, depending upon the nature of the evidence available (see the explanations below). I have compiled this information into a new table which you will find underneath. Of course, these are not all the possible applications of hypnotherapy, simply the ones which currently have the strongest empirical support, based on Wark’s rating using established criteria for research quality. More studies are published every year which potentially meet these criteria and might be included on a future list.

I think it might be observed that certain hypnotherapy treatments for certain types of pain, anxiety, and weight loss are supported by the strongest evidence at present, by this standard. In total, three studies (anxiety due to asthma, public speaking, and taking a test) provide good evidence for the efficacy of hypnotherapy as a treatment for **anxiety**. Assen Alladin’s recent study which provides support for the use of hypnosis in the treatment of **depression** is rated as meeting the “possibly” efficacious criteria. Most of the other studies provide evidence relating to the treatment of acute or chronic **pain**, and certain stress-related or psychosomatic medical conditions such as **insomnia**, **migraine** and **IBS**. Wark even finds one study on hypnotherapy for smoking cessation which meets the criteria for “possibly efficacious.”

This is consistent with a general trend in the literature, since the Victorian era, which tends to point toward hypnotherapy showing most promise in the treatment of anxiety, insomnia, pain management, and several stress-related medical conditions, with mixed findings in relation to its use for the treatment of

habits and addictions such as over-eating, smoking, and alcohol abuse. For example, a committee of experts commissioned by the British Medical Association concluded in 1892 that,

The Committee are of opinion that as a therapeutic agent hypnotism is frequently effective in relieving pain, procuring sleep, and alleviating many functional [i.e., psycho-somatic] ailments.

However, we can now go beyond those early clinical observations and primitive experiments and provide an overview of the therapeutic usefulness of hypnotherapy based on modern research design meeting the highest standards of quality.

| “Specific” empirically supported treatments | | |
|--|---|---------------|
| 1. Anxiety about asthma attack | | Brown, 2007 |
| 2. Headaches and migraine | Relaxation + image modification > wait list control | Hammond, 2007 |

| “Effective” empirically-supported treatments | | |
|---|--|----------------------|
| 3. Cancer pain | | Syrjala et al., 1992 |
| 4. Distress during surgery | Hypnosis reduces distress and pain > controls | Lang et al., 2006 |
| 5. Surgery pain (adult) | Self-hypnosis reduces drug use > attention control | Lang et al., 1996 |
| 6. Surgery pain (child) | Hypnosis reduces pain + hospital time > control | Lambert, 1996 |
| 7. Weight reduction | Hypnosis + CBT > CBT, differences increase over time | Kirsch, 1996 |

| “Possible” empirically-supported treatments | | |
|--|---|------------------------------|
| 8. Acute pain (adult) | | Patterson & Jensen, 2003 |
| 9. Acute pain (children) | Hypnosis > distraction for bone marrow aspiration | Zeltzer & LaBaron, 1982 |
| 10. Anorexia | Staged treatment with hypnosis > same without hypnosis | Baker & Nash, 1987 |
| 11. Anxiety about public speaking | Hypnosis > CBT | Schoenberger et al., 1997 |
| 12. Anxiety about taking a test | Self-hypnosis > discussion control | Stanton, 1994 |
| 13. Asthma | Hypnosis > attention control | Ewer & Stewart, 1986 |
| 14. Bed wetting | Suggestion with or without hypnosis > wait list control | Edwards & Van der Spuy, 1986 |
| 15. Bulimia | Hypnosis = CBT > wait list | Griffiths et al., 1996 |
| 16. Chemotherapy distress | Hypnosis > conversation + antiemetic medication | Jacknow et al., 1994 |
| 17. Cystic fibrosis | Self-hypnosis > wait list control | Belsky & Khanna, 1994 |
| 18. Depression | Hypnosis enhances CBT | Alladin & Alibhai, 2007 |
| 19. Duodenal ulcer relapse | Hypnosis + medication > medication only | Colgan et al., 1988 |
| 20. Fibromyalgia | Hypnosis > physical therapy for subjective symptoms | Haanen et al., 1991 |
| 21. Haemorrhage | Preoperative suggestion reduces blood flow | Enqvist et al., 1995 |
| 22. High blood-pressure | Hypnosis > wait list in reducing BP long-term | Gay, 2007 |
| 23. Hip or knee osteoarthritis pain | Hypnosis = relaxation > wait list control | Gay et al., 2002 |
| 24. Insomnia (primary) | Hypnosis + CBT > medication long-term | Graci & Hardie, 2007 |
| 25. Irritable bowel syndrome (IBS) | Hypnosis > psychotherapy | Whorwell et al., 1984 |
| 26. Nausea & hyperemesis | Hypnotic-like relaxation > control | Lyles et al., 1982 |

| | | |
|----------------------------|---|--------------------------|
| 27. Obstetrics Apgar score | Hypnosis associated with higher Apgar score | Harmon et al., 1990 |
| 28. Obstetrics pain | Hypnosis shortens labour and reduces analgesic use | Jenkins & Prichard, 1983 |
| 29. Smoking cessation | Hypnosis or relaxation > wait list controls for good subjects | Schubert, 1983 |
| 30. Trauma recovery | Desensitisation = hypnosis = psychodynamic therapy > control | Brom et al., 1989 |
| 31. Wart removal | Suggestion with or without hypnosis > control or medication | Spanos et al., 1990 |

These ratings are derived from the review published by Wark (2008), in which the references and criteria are given in full. In brief, the main criteria for the ratings are those set by Chambless & Hollon (1998), which they define *roughly* as follows but see their article for a more specific and detailed account of the criteria.

Possible

A treatment is “possibly” empirically-supported if peer-reviewed studies meet the following minimum criteria. Studies should *normally* contain samples of at least 25 subjects who are randomly assigned to treatment and control groups, i.e., the study is a randomised control trial (RCT). There is a treatment manual or equivalent (such as a hypnosis script) so that the treatment can be replicated in other studies. Treatment must be conducted upon a specific condition which has been adequately assessed, and adequate outcome measures must be used which are subject to suitable statistical analysis. The outcome must *essentially* show the treatment to be significantly more effective than a placebo or no-treatment control group, or equivalent to another empirically-supported treatment.

Effective

A treatment is termed empirically-supported as being “effective” if statistically significant superiority to control group measures have been replicated with completely independent samples or by independent research teams, and data supporting the treatment in question must be shown to predominate if there are conflicting data from other studies.

Specific

A treatment can be considered empirically-supported as “specific” (i.e., better than “non-specific” treatment) if it has shown statistically significant superiority to a placebo (“sham”) therapy or another psychological therapy in at least two independent studies.

References

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