Guest Editorial: Enhancing the Use of Hypnosis in Medical Practice

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Hypnosis was recognized as a legitimate medical tool by the British Medical Society in 1955 and by the American Medical Association in 1958. Furthermore, it has been reported as a useful part of the treatment of medical issues including asthma, burns, chest pain, child birth, hypertension, irritable bowel syndrome, insomnia, obesity, smoking cessation, stress-related and migraine headaches, and shortness of breath. Hypnosis also helps patients reduce chronic pain and acute pain associated with medical procedures such as surgery (Udolf, 1987; Hilgard & Hilgard, 1994; Olness & Kohen, 1996; Anbar, in press). Nonetheless, use of hypnosis is not widespread within standard medical practice. An upcoming issue of the American Journal of Clinical Hypnosis (AJCH) will be devoted to enhancing the use of hypnosis by the medical community. We invite submission of manuscripts on topics surrounding this issue.

Many questions come to mind regarding some of the relevant problems that may be addressed. For the purpose of discussion, I have divided these into three major areas: Promotion, new clinical and educational endeavors, and economic and administrative development that might enhance the use of hypnosis.

Promotion of Clinical Hypnosis

For the purpose of promoting the use of clinical hypnosis, who is the target audience? Possible audiences include patients and their families, students (medicine, nursing, occupational therapy, physical therapy, speech therapy, radiology technicians, and respiratory therapy), postgraduate trainees (including medical residents), practicing clinicians (medical and nursing), health care administrators (hospital administrators and third-party payors), and government officials (including within research granting agencies).

How do we best reach our target audiences? Possible methods include formal presentations at local or national medical meetings, informal roundtables, workshops (1 hour to 20 hours long), articles in the medical literature, and live or taped demonstrations of hypnosis. Is there a downside to doing any of these? How should professional hypnosis societies better promote medical hypnosis?

New Clinical and Educational Endeavors

In order for hypnosis to be accepted widely within the medical community, numerous hypnosis studies will need to be published in medical journals with a high impact factor. Several of the following issues will need to be addressed to achieve this goal.
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How do we best address misconceptions about clinical hypnosis that may preclude its consideration by clinicians? Such misconceptions include misunderstandings about hypnosis which may have arisen as a result of how it has been portrayed in history, literature, movies, and entertainment. Other misconceptions include the perceived length of time required for application of clinical hypnosis and the presumed lack of reimbursement for use of hypnosis within a medical practice.

Is it important to insist that hypnosis is a method of therapeutic communication that should be integrated into standard medical therapy rather than considered as an alternative therapy?

Medical practitioners need to be reminded that psychology can affect the course of disease, and thus that clinical hypnosis may be of benefit in that setting. Who should speak to the medical community about this? Psychologists? Psychiatrists? Physicians? Social Workers?

What are the pivotal medical studies that need to be undertaken in order to promote the use of hypnosis? What are the pivotal studies that already have been done that should be promoted to the medical community? Is understanding of the psychophysiological mechanism of hypnosis essential for its wide adoption into medical practice? Should we focus our resources on studies to better understand its mechanisms? Or, should we focus on the impact of hypnosis on common medical issues such as anxiety, asthma, cancer, obesity, and smoking cessation?

How important is it for hypnosis studies to be conducted in multicenter settings? What are appropriate control groups for studies involving hypnosis, e.g., standard medical therapy or attention-placebo groups? How do we deal with spontaneous use of hypnosis in control groups? For hypnosis treatment groups, do we give uniform instructions to all subjects even though we recognize that hypnosis works best when it is individualized? Perhaps we should urge medical practitioners to focus on the outcomes of hypnosis studies rather than on the uniformity of hypnosis application.

How important are hypnotizability scales in the design of clinical hypnosis research? What elements of hypnosis instruction, if any, should be preserved in most studies? What outcome measures should be evaluated?

Economic and Administrative Development

Large-scale trials of clinical hypnosis are needed in order for it to be accepted as standard medical therapy. Funding for such studies will be critical for their success. Possible sources of funding include the federal government and charitable foundations. However, perhaps insurance companies can be convinced that they should fund studies of clinical hypnosis given the potential cost-savings that can result from its use (e.g., from fewer emergency room visits or earlier discharge following surgery by patients who use hypnosis).

Could pharmaceutical companies be encouraged to fund studies of hypnosis? They may be interested in learning how the use of hypnosis might enhance adherence to drug therapy. Furthermore, the use of hypnosis to decrease anxiety might be the first step of placebo-controlled clinical drug studies for diseases that are known to be worsened and/or triggered by anxiety (e.g., asthma, headaches, insomnia, and irritable bowel syndrome.) Perhaps, patients who respond well to hypnosis are the ones who are least likely to respond to the drug therapy (unless the drug acts as an anxiolytic) because their symptoms were triggered, in large part, by a psychological issue. Also, these patients may be the most likely to demonstrate a placebo effect during clinical trials because responsiveness to suggestion
can include response to an expectation that they might improve in a drug trial. Thus, exclusion of patients who respond to hypnosis from drug trials may allow a larger proportion of the remaining patients to respond to the drug and decrease the proportion who respond in the placebo arm. If so, will pharmaceutical companies be interested in using hypnotic response for exclusion, so that a significant drug effect might be demonstrated with fewer patients, thus decreasing the cost of evaluating the efficacy of a new drug?

How will medical practice change once clinical hypnosis is used widely? Who will provide instruction in hypnosis to the tens of millions of patients who might benefit? Will physicians do this? Alternatively, medical practices might hire other health care providers for the purpose of teaching hypnosis (e.g., nurses, psychologists, or social workers.) How might medical therapy and expenditures change if a large portion of the population is empowered by use of self-hypnosis?

Conclusions

The wide array of unanswered questions in this editorial illustrates how far we have to go to fulfill the mission of putting hypnosis into the main stream of health care. Given the potential importance of hypnosis in the practice of medicine, it is vital for those of us who understand its value to express our ideas to a wide audience, including writing for AJCH. We eagerly anticipate receiving your manuscripts and have set a January 5, 2007 deadline for submissions to this special issue. (Guidelines for publication in AJCH can be found on www.asch.net).

References