Guest Editorial:
Designing Effective Research Protocols for Medical Applications of Hypnosis

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This issue of the Journal focuses on medical applications of hypnosis. The contributed articles describe a spectrum of clinical hypnosis in the primary care fields of obstetrics (VandeVusse, Irland, Berner, Fuller, & Adams, 2007) and pediatrics (Berberich, 2007), as well as the specialty fields of dermatology (Shenefelt, 2007), immunology (Torem, 2007), and pediatric pulmonology (Anbar, 2007). Additionally, two articles describe intriguing advances in our understanding of the neurological mechanisms of hypnotic effects and their potential impact on selection of appropriate treatment for specific patients (Raz, Lamar, Buhle, Kane, & Peterson, 2007; Raz & Michels, 2007).

The importance of hypnosis is underscored by its impact on many different fields of medicine, as illustrated by the clinical hypnosis work reported in this issue. These encouraging findings should prompt the development of convincing clinical research in order to gain broad acceptance of hypnosis within medicine. The majority of published reports regarding hypnosis in medicine are based on uncontrolled, non-blinded interventions, or retrospective analyses; thus their outcome cannot be attributed exclusively to an effect of hypnosis. Therefore, the impartial medical practitioner may wonder about its proposed effectiveness.

It is up to those of us who practice clinical hypnosis to design clinical trials that will be convincing to the medical community. We will need to explain to the medical community that efficacy of hypnosis must be judged by somewhat different standards than is allopathic medicine. For example, hypnosis instruction does not allow blinding of a study in the same way as does administration of a placebo pill.

We must exercise special care in the design of clinical trials, lest we minimize the effect of hypnosis because of an inadequate research protocol. For example, it is important for hypnosis instructions given to study subjects to be as individualized as possible in order to achieve an optimal hypnotic effect, as demonstrated in the clinical hypnosis articles in this issue.

As the rapport established with the therapist is a key for the success of hypnosis, researchers might want to consider how to assess whether this goal has been achieved. For example, subjects may be asked during a research trial to rate
their feelings about their relationship with the hypnosis facilitator. In order to help prepare research subjects to expect a positive outcome from clinical hypnosis, the facilitator might show subjects how to achieve hypnoanalgiesia or other hypnotic manifestations, with an explanation that hypnosis can be very powerful. The suggestion might then be made that just as subjects are able to achieve certain outcomes with hypnosis, they will be able to achieve an improvement in controlling their symptoms.

Depending on the clinical research protocol, some of the following ideas may enhance the efficacy of hypnosis instruction. Subjects might be taught an anchoring gesture that they can utilize as a shortcut to hypnosis at times when they may not have time to do “full hypnosis.” While in hypnosis it might be suggested that the patients’ subconscious will take care of their problem, even when the patient is not doing hypnosis. The results achieved with hypnosis may benefit from the patients’ recognition of their active participation in the process. For example, patients might be asked for feedback regarding how a personalized hypnosis audiotape/CD should be made in order to help them take better ownership of the experience.

Some hypnosis work may depend on the subjects’ utilization of self-hypnosis for the duration of a study. Therefore, researchers should consider how they might maximize the likelihood of this kind of behavior. For example, if patients are asymptomatic during at least part of the study period, their motivation for doing “preventive” hypnosis may decrease with time. Enhancement of on-going subject enthusiasm about doing hypnosis could include asking them to measure a biological response to hypnosis that is to be reported to the researcher (i.e., biofeedback). For example, subjects might be asked to record their pulse after doing hypnosis for 5 minutes every day. Or subjects might be offered a chance to have their skin conductance checked while doing hypnosis and be told that the more they practice hypnosis the lower the achievable conductance. Subjects might be taught how to use hypnosis for reasons other than their primary symptoms, which would give them more incentive to use hypnosis in the long-run (for example, to improve their mental focusing efficiency or athletic performance.)

Clearly, there are many additional issues that must be considered during the design of clinical research protocols. Thus, during each phase of research trial development, researchers should consult with their colleagues who are engaged in clinical hypnosis work in order to receive valuable feedback. Membership in the American Society of Clinical Hypnosis or other scientific hypnosis organizations facilitates such productive interchange. Together, we can lead even more health care providers to a realization that clinical hypnosis should become an indispensable part of the practice of medicine.

References


