To Assess or Not Assess Hypnotic Suggestibility? That is the Question

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To assess or not assess hypnotic suggestibility? That is the question. Dr. Howard Sutcher (2008) reports four cases in which the patients he treated profited from treatment yet “differed vastly in their levels of hypnotizability” (p. 61). He uses this observation to support his position that hypnotic suggestibility scores can tell us very little about treatment outcome. If Dr. Sutcher is correct, then it makes little sense to test for hypnotic suggestibility to assist in treatment planning. However, the case for or against suggestibility assessment should not rest on anecdotal observations and a handful of case studies. Anecdotal observations can generate useful hypotheses; however, they often have limited evidential value and are no substitute for well-controlled studies with relatively large numbers of patients. Indeed, the author reported on standardized hypnotic suggestibility assessment in only one of the four cases he described, so it is questionable as to what extent his observations bear on standardized suggestibility assessment.

Nevertheless, the case studies reported do constitute a demonstration proof that not everyone who is suggestible will respond to a hypnotic treatment, and some patients who are not very suggestible at all will respond to a treatment that incorporates hypnosis. Accordingly there is not a one-to-one relation between suggestibility and treatment outcome. Yet this is hardly a newsflash. Clinicians who use hypnosis will learn very quickly that not all suggestible individuals respond to treatments that incorporate hypnosis. And this is the way it ought to be. Hypnosis itself is not a stand-alone treatment that depends on achieving an absolute threshold of responsivity for success. Rather, it is an adjunctive method that can be valuable when combined with a variety of interventions. Meta-analyses consistently support the efficacy of hypnosis in psychotherapies ranging from psychodynamic to cognitive-behavioral (Kirsch, 1990; Kirsch, Montgomery, & Sapirstein, 1996.).
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Still, if a treatment that includes hypnosis is ineffective or misapplied, it will not “work” regardless of how suggestible the patient appears to be. Conversely, if a treatment is highly effective, or a patient is highly motivated to make life changes, hypnosis may play a negligible role in moderating treatment outcome. In evaluating the effects of suggestibility on the course of treatment, the effects of suggestibility are often if not inevitably confounded with the effectiveness of the treatment that is employed, and patient-therapist variables, including motivation and the therapeutic alliance.

These concerns aside, by examining aggregate outcomes across studies, it is possible to get some idea of the possible predictive value of hypnotic suggestibility in determining treatment success on a more general basis. However, before we consider this point in greater depth, let us consider a study in a very different area. Recently, researchers (Whitmer, Gustafson, Barrett-Connor, Haan, Gunderson, & Yaffe, 2008) determined that a potbelly in middle age more than triples the risk of Alzheimer’s disease. Yet we would not be surprised to learn that someone who is “thin as a rail” in her 40’s develops Alzheimer’s in later life. Nor would we be surprised to learn that someone who weighed 400 pounds throughout his adult years did not develop dementia.

This state of affairs is, of course, analogous to the cases Dr. Sutcher presents in which there is a disjuncture between suggestibility and treatment effects. In any situation in which there is a less than perfect correspondence between two variables, as in the case of waist girth and Alzheimer’s, and in many circumstances in the real world, a plethora of variables can determine a given outcome (e.g., general health status in this case). Closer to our discussion, in studies of hypnosis and psychotherapy, it is often necessary to consider the possible interactions of multiple variables, including expectancies, motivation, attitudes, beliefs, how suggestions are interpreted, imaginative abilities, and perceptions of the relationship. Contrary to Dr. Sutcher’s implication that we know very little about hypnosis, the combined influence of the variables just cited predict a significant amount of variability in hypnotic responding (Lynn, Kirsch, & Hallquist, in press). Understanding the influence and interaction of these variables can play an important role in both clinical assessment and treatment.

The prediction of hypnotic responding and treatment outcome can be daunting. Nevertheless, it is worthwhile for clinicians to be knowledgeable about what the empirical literature says about suggestibility and treatment outcome. We can be on far more secure footing by examining the responses of participants tested under a variety of standardized conditions than by relying on a few case studies that may or may not be representative of larger samples.

Importantly, Dr. Sutcher’s observations jive with the available evidence in two respects. First, there is not a tight relation between hypnotic suggestibility and treatment gains. However, contrary to what the author implies, suggestibility is not completely irrelevant to outcome. In no study reported to date is high hypnotic suggestibility associated with a negative treatment outcome (Lynn & Kirsch, 2006). Moreover, in the following disorders or conditions, the findings relating suggestibility and treatment outcome, while not entirely consistent, are at least somewhat promising: smoking cessation, obesity, warts, anxiety, somatization, conversion disorders, and asthma (Lynn, Meyer, & Shindler, 2003). In a study of the hypnotic treatment of conversion disorder, hypnotic suggestibility proved to be a better predictor of outcome than expectancies (Moene, Spinhoven, Hoogduin, & Van Dyck, 2003). These findings are consistent with a recent study suggesting that a latent trait of hypnotic suggestibility predicts hypnotic performance independent of expectancies (Benham, Woody, Wilson, & Nash, 2006). One reason why suggestibility does not more closely trace treatment outcome is that typical hypnotic interventions rely on relatively easy suggestions that require little hypnotic or imaginative abilities (e.g., relaxation, guided imagery, imaginative rehearsal).
Second, Dr. Sutcher is correct in stating that the best established link between suggestibility and treatment outcome is in the area of pain control: even medium suggestible individuals can benefit from hypnotic analgesia. The case of Aphrodite that the author presents illustrates the not unexpected circumstance in which a patient who fails to respond to suggestions for smoking cessation is highly responsive to suggestions for pain relief. Empirical studies are consistent with Aphrodite’s confession that she probably was not truly committed to stop smoking. That is, motivation to quit smoking appears to be a crucial variable in determining the effectiveness of hypnotic and nonhypnotic smoking cessation treatments (Green & Lynn, 2000). Moreover, several reviews (Brown, 1992; Perry, Gelfand, & Marcovitch, 1979) indicate that suggestibility is more closely tied to non-voluntary problems (e.g., pain, warts, asthma) than voluntary problems (e.g., smoking, overeating).

It bears note that contrary to Dr. Sutcher’s suggestion that “there is no doubt that there is continuing confusion about how to characterize or interpret an individual’s score derived from any one method” (p. 61), there are well defined norms for many standardized suggestibility scales that can provide useful interpretive information. However, we believe that an assessment of the patient should be more comprehensive than merely securing a global score on a single measure of suggestibility. A careful assessment of how the patient perceives hypnosis in relation to the broader treatment methods, and the patient’s unique treatment agenda, is an absolute necessity.

Suggestibility assessment may be especially important when attempting to use hypnosis to produce difficult-to-experience or rare hypnotic phenomena. For instance, the Stanford Hypnotic Clinical Scale for Adults (HCSA:A; Morgan & Hilgard, 1978–1979) contains a “posthypnotic suggestion” item that can be used to assess the subject’s ability to continue to respond to hypnotic suggestions after the actual hypnosis session (for an excellent review of the clinically relevant information elicited with the HCSA:A, see Barnier & Council, in press). Clinically relevant information can be obtained on standardized scales that contain suggestions for age regression, amnesia, hypnotic dreams, and pain relief. Accordingly, a person’s global score on a suggestibility scale may be less informative than the assessment of specific, treatment-relevant suggestions.

Interestingly, one of the cases that Dr. Sutcher presents to demonstrate the futility of hypnosis assessment instead suggests quite the opposite. We refer here to the case of Tammy, a 12-year-old girl who continuously engaged in cough-sneezes (C/S’s). The author stated that he attended a case conference meeting of the Chicago Society of Clinical Hypnosis, during which a number of hypnosis experts attempted to use hypnosis with Tammy, but none of them succeeded in inducing hypnosis. Subsequently, the author decided to try inducing hypnosis via a tension induction and was able to successfully hypnotize the client. The point here is that the previous failed attempts to hypnotize Tammy constituted an informal assessment of her suggestibility, which provided valuable information about Tammy’s (un)responsiveness to hypnotic suggestions for relaxation. The author was able to successfully use the information from this assessment to tailor his methods and free Tammy of the disruptive C/S’s. Clearly, the assessment of hypnosis proved to be invaluable in crafting an intervention congenial to Tammy.

Knowing something about a patient’s response to hypnosis can guide treatment decisions in other areas of application. Some low suggestible people who do not achieve pain reduction when analgesia suggestions are couched in “hypnotic” terms, do achieve significant pain relief when the same suggestions are presented with no hint that hypnosis
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is involved (see Spanos, 1991 for a review). This is probably the case because some patients have counterproductive and recalcitrant attitudes and expectations about hypnosis that interfere with their responsiveness to the analgesia suggestion. In such cases, it is wise to administer analgesia suggestions with no mention of hypnosis (Lynn & Kirsch, 2006).

We were somewhat surprised that Dr. Sutcher did not raise a number of common objections to suggestibility assessment, including the notions that failure to respond to test suggestions can dampen expectancies of successful response to forthcoming suggestions, and that assessment can be experienced as intrusive (Diamond, 1989). However, as we have argued elsewhere (Lynn & Kirsch, 2006), information regarding general suggestibility and responsiveness to targeted suggestions is easy to obtain, can be integrated seamlessly into treatment and assist in developing rapport, and poses little risk to the therapeutic endeavor. Moreover, because waking suggestibility is strongly associated with hypnotic suggestibility (Barber, 1969; Braffman & Kirsch, 1999), a quick gauge of responsiveness can be obtained by administering a variety of suggestions in a nonhypnotic context, thereby leaving the door open to later defining the procedures as “hypnotic,” or deciding to use nonhypnotic methods if the patient proves to be recalcitrant to waking suggestions.

Still, an initial assessment of the patient as “low suggestible” does not necessarily rule out treatment with hypnosis. The challenge for the therapist is to determine why the patient’s response to suggestions is limited. If an impoverished response is based on acceptance of treatment-interfering myths or negative attitudes about hypnosis (e.g., people go into a “trance” and lose control of their actions), many patients can be disabused easily of negative beliefs and experience a variety of suggestions following psycho-education. Moreover, suggestibility can be increased significantly by providing patients with: (a) encouragement to imagine along with suggestions, (b) instructions regarding how to interpret suggestions, and (c) exhortations to assume an active role in enacting suggestions (Gfeller & Gorassini, in press). Indeed assessment can prove to be invaluable in determining not only general responsiveness to suggestions, but also how to leverage patient beliefs, expectancies, and abilities to maximize suggestibility.

So with regard to the question we posed at the outset, we suggest that the answer is “Yes - assess.” Whether or not the clinician decides to administer a formal suggestibility scale, much can be gained by assessing suggestibility in clinical situations.

References


