International Journal of Clinical and Experimental Hypnosis

The Impact of Hypnotic Suggestibility In Clinical Care Settings

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Available online: 01 Jun 2011

To cite this article: Guy H. Montgomery, Julie B. Schnur & Daniel David (2011): The Impact of Hypnotic Suggestibility In Clinical Care Settings, International Journal of Clinical and Experimental Hypnosis, 59:3, 294-309

To link to this article: http://dx.doi.org/10.1080/00207144.2011.570656

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THE IMPACT OF HYPNOTIC SUGGESTIBILITY IN CLINICAL CARE SETTINGS¹

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Abstract: Hypnotic suggestibility has been described as a powerful predictor of outcomes associated with hypnotic interventions. However, there have been no systematic approaches to quantifying this effect across the literature. This meta-analysis evaluates the magnitude of the effect of hypnotic suggestibility on hypnotic outcomes in clinical settings. PsycINFO and PubMed were searched from their inception through July 2009. Thirty-four effects from 10 studies and 283 participants are reported. Results revealed a statistically significant overall effect size in the small to medium range \( r = .24; 95\% \) Confidence Interval = –0.28 to 0.75), indicating that greater hypnotic suggestibility led to greater effects of hypnosis interventions. Hypnotic suggestibility accounted for 6% of the variance in outcomes. Smaller sample size studies, use of the SHCS, and pediatric samples tended to result in larger effect sizes. The authors question the usefulness of assessing hypnotic suggestibility in clinical contexts.

Hypnotic suggestibility, also referred to as hypnotizability and hypnotic susceptibility, refers to the degree to which a participant responds to hypnotic suggestions. Hypnotic suggestibility is typically recognized as a stable individual difference characteristic, as demonstrated by robust test-retest correlations for periods of up to 25 years (Piccione, Hilgard, & Zimbardo, 1989). Classic data from Hilgard (1965) support the position that hypnotic suggestibility roughly conforms to a

¹This research was supported by grants from the National Cancer Institute (CA129094; CA131473) and the American Cancer Society (CRTG 04-213-01-CPPB). The funding agencies had no role in the design, data collection, or data analysis of the study, or in the writing of this manuscript.

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bell-shaped distribution in the population, with fewer people falling at the extremes and most people in the middle. Cross-cultural studies have replicated these findings in Australian (Sheehan & McConkey, 1979), Canadian (Laurence & Perry, 1982), Danish (Zachariae, Sommerlund, & Molay, 1996), Finnish (Kallio & Ihamuotila, 1999), German (Bongartz, 1985), Italian (DePascalis, Russo, & Marucci, 2000), Romanian (David, Montgomery, & Holdevici, 2003), and Spanish (Lamas, del Valle-Inclan, Blanco, & Diaz, 1989) samples.

The construct of hypnotic suggestibility has been conceptualized as a moderator. That is, degree or level of hypnotic suggestibility is proposed to be associated with degree or level of responsiveness to hypnotic suggestions. The higher that an individual scores on a measure of hypnotic suggestibility, the more responsive one would predict that person to be to hypnotic suggestions.

Support for hypnotic suggestibility as a predictor of hypnotic outcomes is strong in the experimental literature. For example, studies have demonstrated that participants scoring higher in hypnotic suggestibility tend to have greater experimental pain relief (Milling, Shores, Coursen, Menario, & Farris, 2007) and color pattern recognition following hypnosis (Kosslyn, Thompson, Costantini-Ferrando, Alpert, & Spiegel, 2000). These studies have led some to conclude that hypnotic suggestibility plays a central role as a predictor of hypnotic responsiveness across a variety of settings (Barabasz & Perez, 2007).

However, despite the experimental evidence, the utility of assessing levels of hypnotic suggestibility in clinical settings, where time is often short and patient burden often high, remains in question for at least three reasons: (a) Assessments of hypnotic suggestibility can often be lengthy (Spanos, Radtke, Hodgins, Stam, & Bertrand, 1983; Weitzenhoffer & Hilgard, 1962) and can take longer to administer than brief efficacious hypnotic interventions themselves (Montgomery et al., 2007); (b) Meta-analyses have supported the position that the vast majority of patients undergoing medical procedures benefit from hypnotic interventions (Montgomery, David, Winkel, Silverstein, & Bovbjerg, 2002; Schnur, Kafer, Marcus, & Montgomery, 2008); and (c) The percentage of patients who benefit from hypnotic interventions in clinical settings far exceeds the percentage of individuals scoring in the high range of hypnotic suggestibility scales (Hilgard, 1965; Montgomery et al., 2002).

The primary goal of this meta-analysis is to assess the influence of hypnotic suggestibility on hypnosis outcomes in the context of clinical settings. Should the influence of hypnotic suggestibility on responses to hypnotic interventions be large (based on Cohen’s criteria [1992]), the argument to screen patients for levels of hypnotic suggestibility would be strongly supported. Clinicians could benefit from assessing patients’ levels of hypnotic suggestibility in order to best determine...
treatment course. However, should the effect fall into the small or medium range, the case for screening patients prior to hypnotic interventions would be less well supported. Additional patient burden, staff time, and costs associated with assessing patients’ levels of hypnotic suggestibility might not be justified. A secondary goal of this meta-analysis is to identify potential factors that might affect the strength or direction of the relationship between hypnotic suggestibility and hypnotic outcomes in clinical settings. In particular, we will examine the influence of sample size, the scale used to assess hypnotic suggestibility, the nature of the outcome, as well as the impact of pediatric versus adult samples.

METHOD

Search Strategy

Two electronic databases, PsycINFO and PubMed were searched from their respective inceptions through the end of July 2009.

For PsycINFO, the major search terms were “hypnosis” and (“hypnotic suggestibility” or “hypnotizability” or “hypnotic susceptibility”) [mp = title, abstract, heading word, table of contents, key concepts]. The limitations placed on the search were peer-reviewed journal, human, English language, abstracts, quantitative study, or treatment outcome/randomized clinical trial. This approach yielded a total of 95 abstracts.

For PubMed, the search terms were (“hypnosis” [MeSH Terms] OR “hypnosis” [All Field]) AND (hypnotizability [All Fields] OR “hypnotic suggestibility” [All Fields] OR “hypnotic susceptibility” [All Fields]) AND (has abstract [text] AND “humans” [MeSH Terms] AND Randomized Controlled Trial [ptyp] AND [lang]). This approach yielded a total of 63 abstracts.

Selection Strategy

The abstracts of all articles identified by electronic searches (158 in total) were carefully screened by the authors in the study to determine if the abstracts met the following inclusion criteria: (a) published in a peer-reviewed journal; (b) full abstract available online; (c) randomized; (d) written in English; (e) included at least one control condition; (f) hypnosis was listed as at least one of the intervention conditions; (g) hypnosis was being used in a clinical population (defined as a medical, dental, or mental health treatment setting); (h) some empirical, validated measure of hypnotic suggestibility; (i) the study had sufficient data to calculate an effect size; and (j) the study was not a duplicate (i.e., if an article was cited in both PubMed and PsycINFO, it was only used once).
Subsequent to abstract review, 18 manuscripts were obtained and read in full. A standardized form assessing the inclusion criteria was completed for each paper. The coauthors then discussed the 18 manuscripts. Based on consensus review by all authors, 10 of the 18 papers were included in the meta-analysis. The reasons for exclusion were as follows: One paper was a case study; in one study a portion of the sample was included in another study already included in the meta-analysis (overlapping data); in three studies, participants were not randomly assigned to study group; one study included an ineligible population; one study had a lack of information regarding hypnosis; and one study did not have sufficient data to calculate an effect size (see Study Flow Chart, Figure 1).

**Data Abstraction and Study Characteristics**

For each of the 10 papers that were accepted for inclusion into the meta-analysis, relevant data were abstracted using a standardized worksheet. Each paper was abstracted independently by two of the coauthors. Any discrepancies were discussed among all of the authors with reference to the original manuscript until consensus was reached. Specific data collected included: (a) results describing the correlation between hypnotic suggestibility and outcomes within hypnosis treatment groups (e.g., $r$, $R^2$, test statistics); (b) the type of clinical setting (i.e., medical/dental vs. mental health); (c) study design; (d) sample size; (e) hypnotic suggestibility scale used; (f) population characteristics (i.e., pediatric vs. adult).

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**Figure 1.** Study flow chart.
Quantitative Data Synthesis

For every study, we calculated an effect size \((r)\) for each association between the predictor of interest (i.e., hypnotic suggestibility) and a hypnosis intervention outcome in hypnosis intervention groups. If a given study had more than one such association, then an \(r\) was computed for each individual association.

The aggregate effect sizes reported below were calculated using the meta-analysis program by Schwarzer (2008) (using the “Effect Sizes \(r\)” utility). The program produced effect sizes weighted by sample size using a random effects model. The random effects model does not assume that the set of effect sizes is homogeneous, and we expected the set of effects to display heterogeneity. Additionally, it has been recommended to use the random effects model, as this model is more generalizable to the broader population of studies (Rosenthal & DiMatteo, 2001).

The results yielded by the program also address two important concerns: the homogeneity of the set of effects and the “file-drawer” problem. Homogeneity of the set of effects is critical, as it indicates the trustworthiness of the overall effect size generated by the meta-analysis (Schwarzer, 2008). To examine homogeneity of the effect sizes, the percent of variance attributable to sampling error versus the percent of variance attributable to systematic factors was examined (\(Q\) statistic). The \(Q\) statistic indicates whether the variability present in the group of effect sizes is significantly greater than chance and thus is suggestive of the presence of potential moderators. Moderator analyses following a finding of heterogeneity of effect sizes (a significant \(Q\) value) were conducted by analyses of variance in SAS 9.2 (SAS Institute Inc., 2009). To examine publication bias, otherwise known as the “file-drawer problem,” we used Orwin’s (1983) method.

Results

Included studies were published between 1991 and July 2009. Sample sizes in the hypnosis groups ranged from 15 to 77.

The 10 studies meeting the inclusion criteria yielded 34 effect sizes. Effect sizes were based on 283 participants within the studies. Table 1 presents the chief characteristics and effect sizes for study.

The aggregated effect sizes demonstrated that hypnotic suggestibility was significantly associated with hypnotic intervention outcomes in clinical settings \((z = 7.56; p < .001)\). The mean effect \((r = .24, 95\% \text{ Confidence Interval} = -0.28 \text{ to } 0.75)\) using a random
### Table 1
*Study Characteristics and Mean Effect Sizes*

<table>
<thead>
<tr>
<th>Study</th>
<th>Clinical Care Context</th>
<th>Design</th>
<th>Hypnosis Group</th>
<th>Total n</th>
<th>Hypnotic Suggestibility Scale</th>
<th>Child vs. Adult</th>
<th>( r ) (mean)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liossi et al. (2006)</td>
<td>Pediatric procedure, related pain</td>
<td>EMLA^b vs. EMLA + hypnosis vs EMLA + attention</td>
<td>15</td>
<td>45</td>
<td>SHCS</td>
<td>Child</td>
<td>.49</td>
</tr>
<tr>
<td>van Dyck &amp; Spinhoven (1997)</td>
<td>Panic disorder with agoraphobia</td>
<td>Exposure vs. Exposure + hypnosis</td>
<td>32</td>
<td>64</td>
<td>SHCS</td>
<td>Adult</td>
<td>.44</td>
</tr>
<tr>
<td>Lang et al. (1996)</td>
<td>Radiological Procedures</td>
<td>Self-hypnosis relaxation vs. Control</td>
<td>16</td>
<td>30</td>
<td>HIP</td>
<td>Adult</td>
<td>.41</td>
</tr>
<tr>
<td>van Dyck et al. (1991)</td>
<td>Headache</td>
<td>Autogenic training vs. Future oriented hypnotic imagery</td>
<td>27</td>
<td>55</td>
<td>SHCS</td>
<td>Adult</td>
<td>.22</td>
</tr>
<tr>
<td>Moene et al. (2003)</td>
<td>Conversion disorder, motor type</td>
<td>Hypnosis vs. Waiting list</td>
<td>20</td>
<td>44</td>
<td>SHCS</td>
<td>Adult</td>
<td>.30</td>
</tr>
<tr>
<td>ter Kuile et al. (1994)</td>
<td>Headache</td>
<td>Cognitive self-hypnosis vs. Autogenic training vs. Waiting list</td>
<td>40</td>
<td>157</td>
<td>SHCS</td>
<td>Adult</td>
<td>.30</td>
</tr>
</tbody>
</table>

(Continued)
Table 1 (Continued)

<table>
<thead>
<tr>
<th>Study</th>
<th>Clinical Care Context</th>
<th>Design</th>
<th>Hypnosis Group $n$</th>
<th>Total $n$</th>
<th>Hypnotic Suggestibility Scale</th>
<th>Child vs. Adult</th>
<th>$r$ (mean)$^a$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lutgendorf et al. (2007)</td>
<td>Invasive medical procedures</td>
<td>Hypnosis vs. Attention vs. Standard</td>
<td>77</td>
<td>241</td>
<td>HIP</td>
<td>Adult</td>
<td>−.05</td>
</tr>
<tr>
<td>Liossi &amp; Hatira (1999)</td>
<td>Bone marrow aspirations</td>
<td>Hypnosis vs. CBT vs. No intervention</td>
<td>10</td>
<td>30</td>
<td>SHCS</td>
<td>Children</td>
<td>.64</td>
</tr>
<tr>
<td>Moene et al. (2002)</td>
<td>Conversion disorder, motor type</td>
<td>Group therapy vs. Group therapy + hypnosis</td>
<td>24</td>
<td>45</td>
<td>SHCS</td>
<td>Adults</td>
<td>.25</td>
</tr>
</tbody>
</table>

$^a$r(mean): mean correlation between hypnotic suggestibility and outcomes in hypnosis groups; $^b$EMLA: eutectic mixture of local anesthetics.
effects model was in the positive direction (greater hypnotic suggestibility was associated with greater effectiveness of hypnosis interventions) and in the small to medium range (Cohen, 1992). Across studies, the effects of hypnotic suggestibility accounted for 6% of the variance in outcomes.

Effect sizes used for this analysis were all drawn from published, peer-reviewed journals, which may raise concerns about publication bias. To address this possible concern, the number of studies with an effect size of zero required to decrease the overall mean effect size to small (based on Orwin, 1983) was calculated. Results indicated that 47 studies with effect sizes of zero would be needed to reduce the small-to-medium effect size of .24 found here to a small effect size of $r = .10$.

Results of homogeneity tests indicated that the sample of effect sizes was heterogeneous ($Q = 142.03, df = 33, p < .001$). These results suggest that moderators are likely to be present.

First, we explored whether sample size was correlated with effect size. Results revealed a significant, negative correlation ($r = -.67, p < .001$). That is, larger studies tended to produce smaller associations between hypnotic suggestibility and outcomes of hypnotic interventions. These results were consistent with the funnel plot (see Figure 2).

Second, we explored whether the particular scale used to assess hypnotic suggestibility affected the association. Effect sizes were divided into those that used the Hypnotic Induction Profile (HIP; Spiegel, 1977; Stern, Spiegel, & Nee, 1979) and those that used the Stanford Hypnotic Clinical Scale (SHCS; Morgan & Hilgard, 1975). Mean effect size for those effects using the HIP ($r = .12; SD = 0.26; based on eight effects$)

![Figure 2. Effect size by study sample size (funnel plot).](image-url)
was significantly lower than for those studies that used the SHCS
\((r = .47; SD = 0.28; \text{based on 26 effects}), F(1, 32) = 9.97; p < .004\).

Third, we examined whether the nature of the outcome variable was related to effect sizes. Outcomes were divided into five categories: pain, anxiety, patient distress, behavioral outcomes, and depression. Descriptive statistics are presented in Table 2. ANOVA output indicates that the moderating influence of outcome category on the association between hypnotic suggestibility and the effectiveness of the hypnotic intervention was not significant, \(F(3, 25) = 2.84; p < .08\). Depression as an outcome was not included in these analyses as there was only a single effect \((r = -.15)\).

Fourth, we considered the influence of age on the results. In three of the studies (Liossi & Hatira, 1999, 2003; Liossi, White, & Hatira, 2006), the samples consisted of pediatric patients. With these studies removed from the data set, hypnotic suggestibility remained significantly associated with hypnotic intervention outcomes in clinical settings with adults \((z = 3.27; p < .001)\). However, the effect shrunk to the small range \((r = .12; 95\% \text{ Confidence Interval} = -0.19 \text{ to } 0.42)\). The average weighted effect size for the pediatric samples was also significant \((z = 10.82; p < .001)\) but was in the large range \((r = .67, 95\% \text{ Confidence Interval} = 0.43 \text{ to } 0.91)\). Further analyses revealed that effect sizes were significantly larger in pediatric samples than in adult samples, \(F(1, 32) = 35.42; p < .001\).

Fifth, three of the studies were conducted with mental health patients (Moene, Spinhoven, Hoogduin, & van Dyck, 2002, 2003; van Dyck & Spinhoven, 1997), and the remainder was with medical patients. There were no differences in effect sizes based on this factor, \(F(1, 32) = 0.73; p < .40\).

**Discussion**

The present meta-analysis represents a review of the studies to date that have included assessments of the moderating influence of hypnotic suggestibility on the effects of hypnotic interventions in pain, anxiety, patient distress, behavioral outcomes, and depression. The mean weighted effect size by outcome type is presented in Table 2.

<table>
<thead>
<tr>
<th>Outcome Category</th>
<th># of Effects</th>
<th>Mean Weighted r</th>
<th>95% Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>12</td>
<td>.38</td>
<td>-0.01 to 0.75</td>
</tr>
<tr>
<td>Anxiety</td>
<td>8</td>
<td>.31</td>
<td>-0.33 to 0.96</td>
</tr>
<tr>
<td>Distress</td>
<td>3</td>
<td>.57</td>
<td>0.12 to 1.01</td>
</tr>
<tr>
<td>Behavioral</td>
<td>10</td>
<td>.07</td>
<td>-0.21 to 0.35</td>
</tr>
</tbody>
</table>
clinical (medical, dental, or mental health) settings. The results revealed
a small-to-medium overall weighted effect size ($r = .24$) (Cohen, 1992)
and raise the question of the overall utility of assessing hypnotic
suggestibility in clinical settings.

The utility of any screening instrument in health care settings lies
in its ability to predict clinical outcomes or to identify patient needs.
With regard to the application of hypnosis interventions, it has been
argued that hypnotic suggestibility is a core construct in the clinic
as well as in the laboratory and is a powerful predictor of outcome.
The present data and practical considerations temper these assump-
tions. First, in aggregate, hypnotic suggestibility only accounted for 6%
of the variance in responsiveness to hypnosis interventions in clinical
settings. Though statistically significant, this effect is relatively small
and suggests little clinical importance. It seems that the assessment
of hypnotic suggestibility prior to offering a hypnosis intervention
will predict which clinical patients will do slightly better, and not
much more. Second, several assessment approaches to hypnotic sug-
gestibility are often lengthy (e.g., SHCS; Morgan & Hilgard, 1975;
Carleton University Responsiveness to Suggestion Scale; Spanos et al.,
1983), even taking more time to administer than hypnosis itself (e.g.,
Montgomery et al., 2007). Briefer measures, like the HIP (Spiegel,
1977), could be used, but the present data suggest that the predic-
tive utility of the briefer HIP in this context is significantly less than
that of other lengthier measures, negating the time savings advantage.
Perhaps, a better briefer measure of hypnotic suggestibility is needed
for clinical settings. Third, with regard to the patient’s experience,
assessment of hypnotic suggestibility could be counterproductive. The
vast majority of hypnotic suggestibility measures include very difficult
items (e.g., amnesia, hallucinations), ensuring that most patients will
have failure experiences. Such failures are likely to negatively affect
expectancies for positive clinical outcomes, which according to theory
(Kirsch, 1999), meta-analysis (Sohl, Schnur, & Montgomery, 2009), and
empirical studies (Montgomery, Hallquist, et al., 2010; Montgomery,
Schnur, Erblich, Diefenbach, & Bovbjerg, 2010) contribute to hypno-
sis intervention effects. In essence, patients may respond better to
hypnosis interventions, and receive greater clinical benefit, if they
do not go through the hypnotic suggestibility assessment process.
In our clinical experience, breast cancer patients who reported hav-
ing benefited from our hypnosis interventions are often puzzled and
disappointed when they do not “score well” on hypnotic suggestibil-
ity measures. It can take a fair amount of time to reassure them
that their “hypnotic suggestibility” score does not in any way dimin-
ish their prior response to hypnosis, nor does it mean they will not
benefit in the future. Fourth, clinical effect sizes for hypnosis interven-
tions in clinical settings have consistently been in the medium-to-large
range (Montgomery et al., 2002; Schnur et al., 2008). Given that the majority of patients (up to 89%) (Montgomery et al., 2002) benefit from hypnosis interventions in clinical settings, the most efficient and least burdensome clinical approach may be to simply administer the intervention.

Examination of potential moderators of the effects of hypnotic suggestibility in clinical settings yielded several interesting findings. First, effects sizes were significantly and negatively correlated with sample sizes. Larger effect sizes tended to be found in smaller samples, and smaller effect sizes tended to be reported in larger samples. These results raise the question of whether effect sizes describing the influence of hypnotic suggestibility were biased by (statistically speaking) small sample size reports. For example, the strongest correlations ($r = .81$) were reported in sample sizes of only 20 participants (Liossi & Hatira, 2003).

Another potential explanation of the results regarding the inverse correlation of sample size and effect size is that the studies by Liossi and colleagues, which have both small sample sizes and large effect sizes (Liossi & Hatira, 1999, 2003; Liossi et al., 2006), involved pediatric patients. Removing these studies from the sample resulted in a smaller overall effect size. It is possible therefore that the effects of hypnotic suggestibility in clinical populations are stronger in pediatric populations than among adults. This area deserves further study.

Effect sizes did not significantly differ based on outcome category (see Table 2). However, the results ($p < .08$) are somewhat provocative, and there may be a tendency to have smaller effects with behavioral outcomes. As they stand, the results are consistent with other reports indicating that effects of hypnosis interventions are equivalent across clinical outcome categories in medical settings (Montgomery et al., 2002). However, differences in the effects of hypnotic suggestibility may indeed vary across outcomes if enough statistical power were available. This is an additional area that deserves greater scientific attention.

An important limitation of the present article is that the studies with the largest effect sizes were both small sample size studies and involved pediatric patients. It is therefore impossible to determine whether effects are due to sampling error or due to the difference in the developmental stage of the population. If one were to design a new study testing associations between hypnotic suggestibility and hypnosis outcomes, the present results (an $r = .24$) suggest that a sample size of 132 participants would be required to maintain power above the traditional .80 with a two-tailed alpha of .05 (Gorman, Primavera, & Allison, 1995).

A second limitation of the analysis is that given the length of time that hypnosis has been used in clinical settings (over a century; Gravitz, 1988), and the length of time the SCHS and HIP have existed,
there are relatively few articles that included assessments of hypnotic suggestibility as a potential moderator. This lack of studies could reflect the limited real-world practicality of the assessments overall, or simply a clinical focus on improving outcomes.

In conclusion, the present data support the position that there is a small but significant association between hypnotic suggestibility and hypnosis intervention outcomes in clinical settings. However, given that hypnotic suggestibility only accounted for 6% of the variance in outcomes, from the clinical perspective, there appears to be an imbalance between the value of the information gained and the burden of administering hypnotic suggestibility assessments in these settings. It would be of interest to determine if these results are consistent across a variety of clinical populations, ages, and outcomes. Based on the literature, it appears that clinical success or failure of a hypnotic intervention does not hinge on level of hypnotic suggestibility.

References


Die Auswirkungen hypnotischer Suggestibilität in klinischen Behandlungsumgebungen

Guy H. Montgomery, Julie B. Schnur und Daniel David

mittleren Bereich \((r = 0,24, 95\% \text{ Konfidenzintervall} = -0,28 \text{ bis } 0,75)\), welche darauf hinweist, dass eine größere hypnotischen Suggestibilität zu größeren Wirkungen der Hypnose-Interventionen geführt hat. Hypnotische Suggestibilität erklärt 6\% der Varianz der Ergebnisse. Studien mit einer kleineren Stichprobengröße und pädiatrische Stichproben führten zu stärkeren Effektgrößen. Die Autoren diskutieren die Nützlichkeit der Beurteilung der hypnotischen Suggestibilität in klinischen Kontexten.

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\textit{University of Konstanz, Germany} 
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L’impact de la suggestibilité hypnotique en milieu clinique

Guy H. Montgomery, Julie B. Schnur et Daniel David

Résumé: On a décrit la suggestibilité hypnotique comme un puissant indice des résultats associés aux interventions hypnotiques. Toutefois, la documentation existante n’offre aucune approche systématique pour quantifier cet effet. La présente méta-analyse évalue l’ampleur de l’effet de la suggestibilité hypnotique sur les résultats de l’hypnose dans des milieux cliniques. Une recherche a été effectuée dans les bases de données PsycINFO et PubMed, compilées depuis leur création jusqu’en juillet 2009. Cette recherche a répertorié 34 effets tirés de 10 études comptant 283 participants. Les résultats ont révélé un effet global statistiquement significatif dans des portées allant de courte à moyenne \((p = 0,24; \text{ Intervalle de confiance de } 95\% = -0,28 \text{ à } 0,75)\), ce qui indique qu’une plus grande suggestibilité hypnotique accentue les effets des interventions hypnotiques. La suggestibilité hypnotique comptait pour 6\% de la variance dans les résultats. Des études portant sur de plus petits échantillons, sur l’utilisation de l’échelle clinique de susceptibilité hypnotique de Stanford (SHCS) et sur un échantillonnage pédiatique avaient tendance à obtenir des effets plus importants. Les auteurs remettent en question l’utilité d’évaluer la suggestibilité hypnotique dans des contextes cliniques.

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El impacto de la sugestionabilidad hipnótica en el contexto clínico

Guy H. Montgomery, Julie B. Schnur, y Daniel David

Resumen: Se ha descrito a la habilidad hipnótica como un fuerte predic- tor de resultados terapéuticos asociados a intervenciones hipnóticas. Sin embargo, no ha habido intentos sistemáticos para cuantificar este efecto en la literatura. Este meta-análisis evalúa la magnitud del efecto de la habilidad hipnótica sobre resultados hipnóticos en contextos clínicos. Se buscó en PsycINFO y PUBMED desde su inicio hasta julio 2009. Se reportaron 34 efectos de 10 estudios y 283 participantes. Los resultados muestran un tamaño de efecto estadísticamente significativo en el rango de pequeño a mediano \((r = .24; 95\% \text{ Intervalo de Confianza} = -0.28 \text{ a } 0,75)\), indicando que mayor
habilidad hipnótica propicia mayores efectos con intervenciones hipnóticas. La habilidad hipnótica explica el 6% de la varianza de los resultados. Estudios con tamaños de muestra más pequeños, uso de la ECSH, y muestras pediátricas tendieron a producir tamaños de efecto mayores. Los autores cuestionan la utilidad de evaluar habilidad hipnótica en contextos clínicos.

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