



DOSSIER · THERAPY

# Hypnotherapy

The database includes studies on **hypnotherapy**, a significant proportion of which focus on humans. Research centres on **cognitive functions**, **fatigue**, and **gastrointestinal complaints**. The most robust evidence comes from controlled trials on **irritable bowel syndrome (IBS)** and **pain management**, while other applications remain methodologically heterogeneous.

**1,199**

STUDIES IN  
TOTAL

**866**

IN HUMANS

**399**

OF WHICH  
CONTROLLED

**5**

IN ANIMALS

**0**

IN THE LAB

Figures from the IHR study database · Last updated 2026-10-04

## How to Read This Dossier

**ESTABLISHED**

measured in humans, with a comparison group

**PLAUSIBLE**

supported by mechanism, animal studies or observation

**HYPOTHESIS**

a likely connection that still needs to be tested

Hypnotherapy at a Glance

**ORIGIN:**  
Hypnotherapy is a psychotherapeutic method that utilises trance states to focus attention and convey suggestions for changes in perception, behaviour, or physiological processes. Developed from mesmerist approaches in the 18th century, it was systematised in the 20th century through clinical psychology and neuroscience. It is administered by trained therapists using language, imagery, or relaxation techniques.

**EVIDENCE BASE:**  
1,199 evaluated studies · 399 controlled human trials · 467 observational studies · 74 review articles · 5 animal studies · 0 cell culture studies

- STRONGEST EVIDENCE AREAS:**
- Bowel and Microbiome (Irritable Bowel Syndrome, IBS) Controlled trials showed reductions in pain intensity and frequency among IBS patients, with long-term effects lasting years. Group hypnotherapy (HT) resulted in clinically relevant improvements in 54.3% of patients (vs. 25% with standard therapy).
  - **Oncology:** (procedural pain, hot flushes) HT reduced hot flushes by 68% in breast cancer patients and improved anxiety, depression, and sleep quality. In children with cancer, HT significantly reduced pain and anxiety prior to needle procedures compared to controls.
  - Pain Management (non-cardiac chest pain, NCCP) 80% of HT patients with NCCP reported global pain improvement (vs. 23% controls), with significant reductions in pain intensity. Effects were sustained long-term.
  - Fatigue and Stress (hot flushes, postmenopausal) HT reduced hot flushes by 74% in postmenopausal women (vs. 17% controls) and improved sleep quality and daily functioning after 12 weeks.
  - Inflammatory Conditions (ulcerative colitis) HT extended remission duration in ulcerative colitis by 78 days and increased the remission rate at 52 weeks to 68% (vs. 40% controls).

- LIMITATIONS:**
- Data on **chronic inflammatory diseases** (e.g., Crohn's disease) or **skin conditions** (e.g., atopic dermatitis) from controlled human trials are limited. Direct comparisons with pharmacological therapies (e.g., antidepressants) in controlled studies are rare.
  - Studies on **cardiovascular diseases** or the **immune system** in controlled settings are few. Methodological weaknesses in some trials, such as small sample sizes, lack of blinding, and heterogeneous control conditions, limit the robustness of findings.
  - It remains unclear whether HT **directly influences physiological parameters** (e.g., bowel motility, inflammatory markers) or primarily acts via psychological mechanisms (e.g., stress reduction).

**CLASSIFICATION:**  
Hypnotherapy is an evidence-based psychotherapeutic method with demonstrated efficacy in controlled trials for irritable bowel syndrome, procedural pain in oncology, and stress-related symptoms, though its neurobiological mechanisms require further clarification.

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1. What Hypnotherapy Is

**Hypnotherapy** is a psychotherapeutic method that uses **trance states** to **focus attention** and convey **suggestions** for changes in perception, behaviour, or physiological processes. Originating in the 18th century from mesmerist approaches, it was systematised in the 20th century through clinical psychology and neuroscience. It is delivered by trained therapists who induce an altered state of consciousness via **language, imagery, or physical relaxation techniques**. Standardised protocols exist for applications such as **pain reduction, anxiety management, or gastrointestinal disorders**, though session duration and frequency vary.

The **central mechanism of action** in hypnotherapy involves the **modulation of attention and expectation**, which is neurobiologically associated with changes in **prefrontal, limbic, and sensory brain regions**. Studies demonstrate that hypnotic suggestions can influence **pain perception, autonomic functions** (e.g., bowel motility), and **emotional regulation**. **Measurability** is assessed via **subjective scales** (e.g., pain intensity), **physiological markers** (e.g., skin conductance), or **functional imaging**. A key challenge is **standardisation**: trance induction and suggestions vary in effectiveness between individuals, and **therapist dependency** complicates reproducibility. Additionally, the lack of uniform definitions for **“hypnotic depth”** or **“responsiveness”** hinders comparisons across studies.

2. What the Studies Show in Detail

The foundational human studies and key reviews—organised by application, including population, duration, preparation, outcome measures, and results as reported in the original publications. Figures are included only where explicitly stated in the study.

Distribution of **controlled human trials** by application—numbers are non-additive as a single study may cover multiple areas:

| APPLICATION                 | CONTROLLED TRIALS |
|-----------------------------|-------------------|
| Cognition and Mental Health | 220               |
| Fatigue and Stress          | 120               |

| APPLICATION             | CONTROLLED TRIALS |
|-------------------------|-------------------|
| Safety and Tolerability | 76                |
| Bowel and Microbiome    | 66                |
| Oncology                | 55                |
| Musculoskeletal System  | 31                |
| Cardiovascular System   | 14                |
| Inflammatory Conditions | 14                |

## Bowel and Microbiome

The HT intervention comprised six sessions over three months, combined with home practice. Primary endpoints were pain intensity and frequency, measured via weekly pain diaries. After one year, pain intensity in the HT group decreased from 13.5 to 1.3 points (scale 0–20), and frequency from 13.5 to 1.1 days/week—significantly more than in the SMT group (intensity: 14.1 to 8.0; frequency: 14.4 to 9.3 days/week;  $p < 0.001$ ). Clinically relevant improvement was observed in 54.3% of HT patients vs. 25% of SMT patients. Limitation: No blinding, small sample size <sup>2</sup>.

A 2016 RCT compared HT with a **low-FODMAP diet** in 74 IBS patients. The HT group received one hour of hypnotherapy weekly for six weeks, while the diet group followed strict nutritional guidelines. The primary endpoint was change in overall symptoms (visual analogue scale, VAS) after six weeks. Both groups showed similar improvements (HT: -33 points; diet: -30 points;  $p = 0.67$ ), with  $\geq 20$  mm VAS reduction achieved in 72% (HT), 71% (diet), and 72% (combination). After six months, 74% (HT), 82% (diet), and 54% (combination) maintained improvements. HT also led to significantly greater psychological improvements (e.g., anxiety, depression). Limitation: No placebo control for HT, short follow-up.

A long-term follow-up study (2012) examined 52 children from a previous RCT (HT vs. SMT) after an average of 4.8 years. 68% of HT patients remained in remission (vs. 20% in SMT;  $p = 0.005$ ), with significantly lower pain scores (intensity: 2.8 vs. 7.3; frequency: 2.3 vs. 7.1;  $p < 0.01$ ). Somatisation scores also improved (15.2 vs. 22.8;  $p = 0.04$ ). Limitation: Observational design, no re-randomisation.

In an RCT involving 100 therapy-refractory IBS patients (2013), **group HT** (10 weekly sessions) was compared with SMT. The primary endpoint was improvement in the *IBS Impact Scale* at 12 months. 54.3% of HT patients vs. 25% of SMT patients showed clinically relevant improvements ( $p = 0.004$ ). HT also led to significant improvements in quality of life and psychological well-being. Limitation: No blinding, high drop-out rate (10%) <sup>7</sup>.

An RCT from 2013 tested HT in 54 patients with **remitting ulcerative colitis**. The HT group received seven sessions over three months. The primary endpoint was the proportion of patients in clinical remission at 52 weeks. 68% of HT patients vs. 40% of controls remained in remission ( $p = 0.04$ ), with a mean remission prolongation of 78 days. No differences were observed in quality of life or medication adherence. Limitation: Small sample size, single-centre study <sup>5</sup>.

**HYPOTHESIS** The data suggest that HT is particularly effective in **classic IBS** (without dominant psychopathology) and in **children/adolescents**. The effects appear to be long-term stable, even in therapy-refractory cases. It remains unclear whether HT directly influences gut motility or primarily acts via psychological mechanisms—physiological parameters (e.g., barostat measurements) showed no changes <sup>15</sup>.

Missing studies: Long-term data on HT in **organic bowel diseases** (e.g., Crohn's disease), direct comparisons with **pharmacological therapies** (e.g., antidepressants), and investigations into **cost-benefit aspects** in clinical practice.

## Oncology

An RCT from 2008 examined HT in **60 female breast cancer patients** with hot flushes. The intervention group received five weekly HT sessions, while controls received no treatment. The primary endpoint was the change in the *Hot Flash Score* (frequency  $\times$  severity). After 12 weeks, the score in the HT group reduced by 68% ( $p < 0.001$ ), whereas controls showed no significant change. Secondary improvements were observed in anxiety, depression, and sleep quality. Limitation: No placebo control, short follow-up <sup>3</sup>.

In an RCT from 1999, **30 children (aged 5–15) with cancer** undergoing bone marrow aspirations were treated with either HT, cognitive behavioural therapy (CBT), or no intervention. HT and CBT significantly reduced pain and anxiety more than the control ( $p < 0.05$ ), with HT leading to fewer behavioural issues. Limitation: Small sample size, no blinding.

An RCT from 2003 tested HT in **80 children (aged 6–16)** before lumbar punctures. The HT group (direct or indirect suggestions) showed significantly less pain and anxiety than controls ( $p < 0.05$ ). Hypnotisability correlated with therapeutic success. Limitation: Effects diminished when patients switched to self-hypnosis—the therapist's presence appears crucial.

**HYPOTHESIS** HT may be particularly helpful for **procedural pain** (e.g., punctures) and **hot flushes**, possibly by reducing anxiety and improving self-regulation. However, the limited data for **chronic pain** in cancer patients do not yet allow conclusions, and findings on **self-reported fatigue scores** remain inconclusive. It remains unclear whether HT is similarly effective in **adults with advanced tumours** as in children.

Missing studies: Comparisons of HT with **pharmacological analgesics** (e.g., opioids), long-term data on **fatigue** or **quality of life** in oncology patients, and investigations into **combination therapies** (e.g., HT + chemotherapy).

## Fatigue and Stress

An RCT from 2013 examined HT in **187 postmenopausal women** with  $\geq 7$  hot flushes/day. The HT group received five weekly sessions, while controls received structured attention. The primary endpoint was the subjective reduction in hot flushes at 12 weeks. The HT group reduced frequency by 74% (vs. 17% in controls;  $p < 0.001$ ), with improvements in sleep quality and daily impairment. Limitation: No blinding, no physiological measurement of hot flushes <sup>4</sup>.

**HYPOTHESIS** HT might help with **subjective stress-related symptoms** (e.g., hot flushes, sleep disturbances) by modulating distress perception. However, its impact on **autonomic regulation** in humans remains untested, and data on **self-reported fatigue** (e.g., in Long-COVID) or **occupational stress** are lacking.

Missing studies: Comparisons of HT with **relaxation techniques** (e.g., progressive muscle relaxation), long-term data on **burnout** or **chronic fatigue syndrome**, and investigations into **combination therapies** (e.g., HT + mindfulness).

## Cognition and Psyche

An RCT from 2006 tested HT in **28 patients with non-cardiac chest pain (NCCP)**. The HT group received 12 sessions over 17 weeks, while controls received supportive therapy plus placebo. The primary endpoint was global pain improvement. 80% of HT patients vs. 23% of controls reported improvement ( $p=0.008$ ), with a significantly greater reduction in pain intensity ( $p=0.046$ ). The study showed a potential benefit, but the small sample size and lack of blinding limit the conclusions <sup>6</sup>.

In an RCT from 2022, HT was compared with **virtual reality (VR)** in 100 patients before/after cardiac surgery. The HT group received 20-minute sessions on two days. The primary endpoint was the change in anxiety and pain. Both groups showed anxiety reduction, but no significant differences between HT and VR. Limitation: No placebo control, short intervention.

An observational study from 2003 followed **204 IBS patients** for up to six years after HT. 71% initially responded to HT, of whom 81% remained improved long-term. Symptom scores, quality of life measures, and psychological distress showed significant improvements ( $p<0.001$ ). Limitation: No control group, retrospective data collection <sup>13</sup>.

**HYPOTHESIS** HT appears effective for **psychosomatic pain** (e.g., NCCP, IBS), possibly by **reducing catastrophising** and **improving pain coping**. However, the evidence for **trait anxiety** or **depression** in controlled trials is inconsistent—some studies show effects, others do not.

Missing studies: Comparisons of HT with **cognitive behavioural therapy (CBT)** for anxiety disorders, long-term data on **post-traumatic stress disorder (PTSD)**, and investigations into **neurobiological mechanisms** (e.g., fMRI studies).

## Skin

An observational study from 2002 examined HT in **250 IBS patients** (18 of whom underwent additional barostat measurements). Patients received 12 sessions over three months. HT significantly improved all IBS symptoms ( $p<0.001$ ) but did not alter **rectal pain thresholds** or **gut tone** in the measured subgroup. Psychological factors (somatisation, anxiety) improved markedly. Limitation: No control group, no blinding <sup>15</sup>.

**HYPOTHESIS** HT may be effective for **skin-related psychosomatic symptoms** (e.g., itching, neurodermatitis) by reducing **psychological triggers**. However, specific studies on skin conditions are lacking.

Missing studies: RCTs on HT for **neurodermatitis**, **psoriasis**, or **chronic itching**, as well as investigations into **immunological effects** (e.g., cytokine profiles).

## Inflammatory Processes

A 2018 review summarises the evidence on **psychogastroenterological therapies** (including hypnotherapy and other approaches) in inflammatory bowel diseases. In a randomised controlled trial (RCT) on **ulcerative colitis** included in the review, HT extended remission duration by 78 days ( $p=0.03$ ) and achieved a higher remission rate after 52 weeks (68% vs. 40%;  $p=0.04$ ). Potential mechanisms such as **stress reduction** were observed, while **immune modulation** remains a hypothesis, as the study did not measure inflammatory markers.

**HYPOTHESIS** HT may exert effects in **chronic inflammatory diseases** (e.g., IBS, ulcerative colitis) via **psychoneuroimmunological pathways**. Research on **systemic inflammatory markers** (e.g., CRP, cytokines) stands out as a key question for future studies.

Missing studies: RCTs on HT in **Crohn's disease**, investigations into **molecular mechanisms** (e.g., gut microbiome, epigenetics), and long-term data on **disease progression**.

## Overall Picture

Controlled human trials on hypnotherapy (HT) provide robust evidence in **gastroenterological applications** (particularly IBS): they showed significant improvements in symptoms, quality of life, and psychological distress, with effects lasting for years. HT appeared particularly effective in **classic IBS** (without dominant psychopathology) and in **children/adolescents**, whereas older patients (>50 years) or those with atypical symptoms responded less well <sup>14</sup>. In **oncology**, controlled trials showed that HT reduced procedural pain and hot flushes, with stronger effects observed in children than in adults. For **psychosomatic pain** (e.g., non-cardiac chest pain, NCCP) and **stress symptoms** (e.g., hot flushes), controlled studies indicated moderate effects, though often without clear superiority over other psychological interventions (e.g., CBT).

The evidence base for **chronic inflammatory diseases** (e.g., Crohn's disease), **dermatological conditions**, or **neurological applications** (e.g., epilepsy) from controlled human trials is limited or absent. Furthermore, many controlled studies are constrained by **small sample sizes**, **lack of blinding**, or **short follow-up periods**. Systematic comparisons with **pharmacological therapies** (e.g., antidepressants, antispasmodics) or **other non-pharmacological interventions** (e.g., acupuncture, diets) are rare. It also remains unclear whether HT **directly influences physiological parameters** (e.g., gut motility, inflammatory markers) or primarily acts via **psychological mechanisms** (e.g., stress reduction).

### Methodology of the evidence base

[

MOST CONTROLLED STUDIES ON HT ARE

randomised controlled trials (RCTs) with active controls (e.g., supportive therapy, diets) or waitlist controls. Typical intervention durations range from 6–12 sessions over 3–6 months, with follow-ups of 6–12 months (in some cases up to 6 years). Primary endpoints usually include symptom scores (e.g., pain intensity, frequency), quality of life (e.g., IBS Impact Scale), or clinical remission (≥50–80% improvement). Secondary endpoints often comprise psychological parameters (anxiety, depression) or physiological measurements (e.g., barostat, skin conductance). Systematic weaknesses include: (1) lack of blinding (HT is difficult to blind), (2) small sample sizes (n<100 in 80% of controlled studies), (3) short follow-up periods (usually <1 year), (4) no placebo controls for psychological effects, and (5) insufficient standardisation of HT protocols (e.g., individual vs. group HT). Missing studies: dose-response relationships, long-term data on adverse effects, cost-benefit analyses, and neurobiological mechanisms\*\* (e.g., fMRI, EEG).

Hypnotherapy: Efficacy or placebo effect?

DISTINGUISHING BETWEEN SPECIFIC EFFECTS AND PLACEBO

remains a key challenge. Controlled studies demonstrate that hypnotherapy can exceed placebo effects—for example, in pain reduction or gut motility—yet the mechanisms remain unclear. Neuroimaging studies confirm changes in pain processing and cognitive control, but whether these are causally linked to clinical outcomes is unresolved. Furthermore, blinded studies controlling for therapist and patient expectations are lacking. Even in cases of positive results, it is unclear whether effects stem from hypnotic suggestions, relaxation, or non-specific therapeutic elements.

Another issue is

INSUFFICIENT STANDARDISATION

. Responsiveness to hypnosis varies widely among individuals, and predictors of success (e.g., absorption capacity, suggestibility) are inadequately researched. Studies employ diverse induction methods, suggestions, and session durations, complicating comparisons. Additionally, long-term data are still emerging: Most follow-ups conclude after 12 months, despite chronic conditions like irritable bowel syndrome having multi-year trajectories. The generalizability to other populations (e.g., older patients, individuals with psychiatric comorbidities) remains largely unexplored.

3. How Robust Is the Research?

The research landscape on hypnotherapy is broad but unevenly distributed. The majority of human studies are observational or controlled. Most controlled trials investigate cognitive functions and fatigue, followed by gastrointestinal disorders and oncological applications. Irritable bowel syndrome dominates, with one of the most cited studies dating back to 1984, while other areas, such as cardiovascular diseases or the immune system, are scarcely represented. Reviews focus on mechanisms and meta-analyses, with a systematic review from 2014 receiving the most attention.

The robustness of the data varies considerably. Controlled studies on irritable bowel syndrome and pain show consistent effects, particularly in long-term follow-ups (e.g., 2012: 5-year follow-up in children). Methodological strengths include randomised designs and standardised protocols (e.g., 'gut-directed hypnotherapy'). Weaknesses include small sample sizes, lack of blinding (therapist and patient are usually not blinded), and heterogeneous control conditions (e.g., waitlist vs. active therapy). Observational studies provide indications of long-term effects but cannot establish causality. Basic research suggests neurobiological correlates but often remains correlational.

4. Common Claims—and What the Data Support

| STATEMENT                                                                                                                        | EVIDENCE BASE                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Hypnotherapy is effective for all pain conditions   Limited evidence; effects vary by condition and individual responsiveness.   | Controlled studies demonstrate effects primarily in procedural pain (e.g., bone marrow aspirations) and irritable bowel syndrome. For chronic back pain or   |
| Hypnotherapy can replace pharmacological therapies   No; it may complement but not replace established treatments in most cases. | Studies typically compare hypnotherapy with standard treatment or a waiting list, rather than active controls (e.g., cognitive behavioural therapy). An addi |

| STATEMENT                                                                                                          | EVIDENCE BASE                                                                                                                                                                              |
|--------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Children respond better to hypnotherapy</b><br>  Supported by data, particularly in IBS and procedural pain.    | Studies in children demonstrate <b>high responsiveness</b> (e.g., in functional abdominal pain), but <b>no systematic comparisons</b> with adults. The <b>age dependence</b> ;             |
| <b>Hypnotherapy works beyond placebo</b>   Some evidence suggests specific effects, but mechanisms remain unclear. | Controlled studies indicate <b>specific effects</b> , yet <b>blinded designs</b> are lacking. Whether the effects are attributable to <b>hypnotic suggestions</b> or <b>non-specific</b> f |

## 5. The Most Robust Studies

Ranked by evidential strength, not by prominence. The full evaluation includes many more studies; these represent the most reliable.

### Controlled Human Studies

- <sup>1</sup> Controlled trial of hypnotherapy in the treatment of severe refractory irritable-bowel syndrome (1984)
- <sup>2</sup> Hypnotherapy for children with functional abdominal pain or irritable bowel syndrome: a randomised controlled trial (2007)
- <sup>3</sup> Randomised trial of a hypnosis intervention for the treatment of hot flushes among breast cancer survivors (2008)
- Clinical hypnosis versus cognitive behavioural training for pain management in paediatric cancer patients undergoing bone marrow aspirations (1999)
- Randomised clinical trial: the efficacy of gut-directed hypnotherapy is similar to that of the low FODMAP diet for the treatment of irritable bowel syndrome (2016)
- Long-term follow-up of gut-directed hypnotherapy versus standard care in children with functional abdominal pain or irritable bowel syndrome (2012)
- Psychological treatments for functional gastrointestinal disorders: a primer for the gastroenterologist (2013)
- <sup>4</sup> Clinical hypnosis in the treatment of postmenopausal hot flushes: a randomised controlled trial (2013)
- <sup>5</sup> Gut-directed hypnotherapy significantly augments clinical remission in quiescent ulcerative colitis (2013)
- Clinical hypnosis in the alleviation of procedure-related pain in paediatric oncology patients (2003)
- <sup>6</sup> Treatment of non-cardiac chest pain: a controlled trial of hypnotherapy (2006)
- Integrative medicine therapies for pain management in cancer patients (2019)
- A critical review of approaches to the treatment of dental anxiety in adults (2013)
- <sup>7</sup> Long-term success of gut-directed group hypnotherapy for patients with refractory irritable bowel syndrome: a randomised controlled trial (2013)
- <sup>8</sup> Effects of gut-directed hypnotherapy on IBS in different clinical settings—results from two randomised, controlled trials (2012)
- Standard gastroenterologist versus multidisciplinary treatment for functional gastrointestinal disorders (MANTRA): an open-label, single-centre, randomised trial (2020)
- Virtual reality and hypnosis for anxiety and pain management in intensive care units: a prospective randomised trial among cardiac surgery patients (2022)
- <sup>9</sup> Treatment with hypnotherapy reduces the sensory and motor component of the gastrocolonic response in irritable bowel syndrome (2004)
- Virtual reality hypnosis for pain associated with recovery from physical trauma (2010)
- <sup>10</sup> Hypnosis to manage distress related to medical procedures: a meta-analysis (2008)
- Randomised controlled trial of brief mindfulness training and hypnotic suggestion for acute pain relief in the hospital setting (2017)
- <sup>11</sup> Efficacy of individual and group hypnotherapy in irritable bowel syndrome (IMAGINE): a multicentre randomised controlled trial (2019)
- <sup>12</sup> Home-based hypnotherapy self-exercises versus individual hypnotherapy with a therapist for the treatment of paediatric irritable bowel syndrome and functional abdominal pain: a randomised controlled trial (2017)
- Mediators of a brief hypnosis intervention to control side effects in breast surgery patients: response expectancies and emotional distress (2010)

## 6. Summary

Hypnotherapy (HT) is most robustly evidenced for **gastroenterological applications**, particularly in irritable bowel syndrome (IBS). Several randomised controlled trials (RCTs) demonstrate significant improvements in symptoms, quality of life, and psychological distress, with effects lasting for years. HT appears to be particularly effective in classic IBS without dominant psychopathology, as well as in children and adolescents. In oncology, HT reduces

procedural pain (e.g., aspirations) and hot flushes, with effects more pronounced in children than in adults. For psychosomatic pain (e.g., non-cardiac chest pain) and stress-related symptoms (e.g., postmenopausal hot flushes), HT shows moderate effects, though it often does not clearly outperform other psychological interventions such as cognitive behavioural therapy (CBT).

**HYPOTHESIS** Hypnotherapy (HT) may induce neurobiological changes in prefrontal, limbic, and sensory brain regions through the modulation of attention and expectation. This could explain why HT is particularly effective in functional disorders (e.g., IBS), where psychological factors play a central role. The long-term effects suggest that HT does not merely act symptomatically but may also sustainably improve self-regulation and pain management. In inflammatory bowel diseases such as ulcerative colitis, HT may exert effects through stress reduction and immune modulation; however, direct measurements of inflammatory markers are lacking. **Hypothesis:** HT could produce synergistic effects when combined with other therapies (e.g., diets, pharmacotherapy), particularly in treatment-refractory cases. Currently, there is insufficient evidence to assess the efficacy or mechanisms of HT for dermatological or neurological applications.

Future studies should address the following questions: 1) **Direct physiological effects:** Does HT measurably influence gut motility, inflammatory markers (e.g., CRP, cytokines), or autonomic functions? 2) **Comparisons with standard therapies:** How does HT perform in direct comparison with pharmacological therapies (e.g., antidepressants, antispasmodics) or other non-pharmacological approaches (e.g., acupuncture, diets)? 3) **Long-term data and subgroups:** Which patient groups benefit the most (e.g., age, symptom profile, hypnotisability)? 4) **Cost-benefit aspects:** Is HT cost-effective in clinical practice, particularly for chronic conditions? 5) **Mechanisms:** Which neurobiological or immunological pathways mediate the effects of HT, and how can these be targeted? 6) **Combination therapies:** Can HT enhance the efficacy of other therapies (e.g., chemotherapy, mindfulness), and if so, under what conditions?

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## 7. Unresolved Questions

- **Neurobiological mechanisms:** Which **brain regions** and **neurotransmitters** are causally involved in the effects?
- **Long-term effects:** Do the effects persist for **chronic conditions** over years, or are **booster sessions** required?
- **Predictors:** Can **responders** be identified in advance (e.g., via **suggestibility tests** or **genetics**)?

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## Frequently Asked Questions

Is hypnotherapy evidence-based for irritable bowel syndrome?

Yes, **irritable bowel syndrome (IBS)** has the **most robust evidence base**. Controlled studies demonstrate **significant improvements in symptom severity, quality of life, and bowel motility**, including in the **long-term**. Meta-analyses confirm its **efficacy**, with **gut-directed hypnotherapy** (a standardised protocol) being the best-studied approach. The effects are **comparable to dietary interventions** (e.g., low-FODMAP), though **additive effects** cannot be ruled out.

Can hypnotherapy be used for anxiety disorders?

The evidence base is **limited and heterogeneous**. Controlled studies exist primarily for **situational anxiety** (e.g., dental anxiety, **procedural anxiety** during medical interventions). For **generalised anxiety disorder** or **social phobia**, **randomised trials** are lacking. Observational studies suggest **short-term effects**, but **long-term data** and **comparisons with established therapies** (e.g., cognitive behavioural therapy) are still needed.

How many sessions are required for an effect?

The **number of sessions** varies depending on the **application**. For **irritable bowel syndrome (IBS)**, studies demonstrate **effective outcomes** in the examined areas, with **long-lasting results** even after **years**. For **pain management**, **fewer sessions** are often sufficient (e.g., prior to medical procedures). **Standardised protocols** (e.g., **gut-directed hypnotherapy**) typically involve **regular sessions** over **several months**. **Individual factors** (e.g., **suggestibility**, **therapist-patient relationship**) play a greater role than the **sheer number** of sessions.

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Research, put in context. Every statement leads to the original paper; the decision in the individual case rests with the treating professional.  
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