

Hypnotherapy for smoking cessation (Review)

Abbot NC, Stead LF, White AR, Barnes J



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[Intervention Review]

Hypnotherapy for smoking cessation

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ABSTRACT

Background

Hypnotherapy is widely promoted as a method for aiding smoking cessation. It is proposed to act on underlying impulses to weaken the desire to smoke or strengthen the will to stop.

Objectives

The objective of this review was to evaluate the effects of hypnotherapy for smoking cessation.

Search strategy

We searched the Cochrane Tobacco Addiction Group Specialized Register and the databases MEDLINE, EMBASE, AMED, SCI, SSCI and CISCOP using the terms smoking cessation and hypnotherapy or hypnosis in February 2005.

Selection criteria

We considered randomized trials of hypnotherapy which reported smoking cessation rates at least six months after the beginning of treatment.

Data collection and analysis

Two authors extracted data on the type of subjects, the type and duration of the hypnotherapy, the nature of the control group, the outcome measures, method of randomization, and completeness of follow up.

The main outcome measure was abstinence from smoking after at least six months follow up in patients smoking at baseline. We used the most rigorous definition of abstinence in each trial, and biochemically validated rates where available. Those lost to follow up were counted as smokers. Where possible, we performed meta-analysis using a fixed-effect model.

Main results

Nine studies compared hypnotherapy with 14 different control interventions.

There was significant heterogeneity between the results of the individual studies, with conflicting results for the effectiveness of hypnotherapy compared to no treatment or to advice. We therefore did not attempt to calculate pooled odds ratios for the overall effect of hypnotherapy. There was no evidence of an effect of hypnotherapy compared to rapid smoking or psychological treatment.

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Authors' conclusions

We have not shown that hypnotherapy has a greater effect on six month quit rates than other interventions or no treatment.

The effects of hypnotherapy on smoking cessation claimed by uncontrolled studies were not confirmed by analysis of randomized controlled trials.

PLAIN LANGUAGE SUMMARY

Does hypnotherapy help people who are trying to stop smoking

Different types of hypnotherapy are used to try and help people quit smoking. Some methods try to weaken people's desire to smoke, strengthen their will to quit, or help them concentrate on a quit programme. The review of trials did not find enough good evidence to show whether or not hypnotherapy can help people trying to quit smoking.

BACKGROUND

Hypnotherapy has been recognized as a therapeutic tool by professional medical groups in a number of countries for many years, and can be powerful for changing patterns of behaviour when used as an adjunct to other therapies, such as cognitive behavioural therapy (Kirsch 1995). Clinical research is still limited but some success has been reported for symptom reduction in irritable bowel syndrome (Whorwell 1991), asthma (Morrison 1988), chronic pain (Hart 1994) and for improving the quality of life of cancer patients (Newton 1982). There is, however, little consensus about how hypnotherapy might induce these effects. It is also recognized that treatment success could be influenced by other factors such as the transference relationship between patient and therapist and the hypnotisability of subjects (Perry 1979).

The rationale for hypnotherapy as a useful adjunct for smoking cessation is that, by acting on underlying impulses, it may weaken the desire to smoke, strengthen the will to stop or improve the ability to focus on a treatment programme by increasing concentration (Spiegel 1993). Many different hypnotherapy techniques have been employed but the most frequently used approaches are variants of the 'one session, three point' method developed by Spiegel. This method attempts to modify patients' perceptions of smoking by using the potential of hypnotherapy to induce deep concentration. During the session the smoker is instructed that a) smoking is a poison, b) the body is entitled to protection from smoke, and c) there are advantages to life as a nonsmoker (Spiegel 1964). This approach also includes training in self hypnosis which may be as important as hypnosis by a therapist (Katz 1980). Self hypnosis can be used at will by the patient. Compliance may be

higher and costs lower because only one session is required. In uncontrolled studies six-month abstinence rates using this method are reported to vary between 20 and 35%.

To date, most of the studies in the scientific literature are either case reports or poor quality uncontrolled trials which show a great variability in quit rates (4-88%) six months after treatment. Also, interpretation of these studies is complicated by the many different hypnotherapy regimens used and the variation in number and frequency of treatments (Holroyd 1980). The purpose of this review is to assess the efficacy of hypnotherapy for smoking cessation from all the relevant trials purporting to be randomized and controlled.

OBJECTIVES

To evaluate the effectiveness of hypnotherapy as a treatment for smoking cessation.

We set out to test the following hypotheses:

- a) That hypnotherapy has a therapeutic effect in achieving long-term smoking cessation compared with no intervention.
- b) That the magnitude of the effects observed with hypnotherapy is greater than with other intervention strategies.

METHODS

Criteria for considering studies for this review

Types of studies

Randomized controlled trials comparing hypnotherapy with no treatment or with other therapeutic interventions.

Types of participants

Smokers who wish to stop smoking, irrespective of gender, number of years smoking or level of nicotine dependence.

Types of interventions

We considered any trial of hypnotherapy for smoking cessation. As one of the difficulties in showing the effectiveness of hypnotherapy is that there are many different techniques, we took into consideration the type and duration of therapy.

Types of outcome measures

Abstinence from smoking assessed at follow up at least six months from the start of treatment. Both validated abstinence based on biochemical markers and abstinence based on self report by telephone and postal questionnaires were accepted.

Search methods for identification of studies

We identified all reports which might describe randomized controlled trials (RCTs) of hypnotherapy for smoking cessation from the Cochrane Tobacco Addiction Group Specialized Register. Additional search strategies used to identify studies included: searches of MEDLINE (Silverplatter 1966-2005/02), EMBASE (Silverplatter 1980-2005/01), the ISI Science Citation and Social Science Citation Indexes (BIDS 1981-2005, Web of Science 2000-2005/1), AMED (Allied and Alternative Medicine database) (Silverplatter 1985-2005/2), and CISCOM using the terms "hypnotherapy" and "smoking cessation", and cross-referencing the bibliographies of identified trials and reviews.

Data collection and analysis

We checked all of the trials identified against the inclusion criteria. The three authors independently assessed the quality of the trials meeting the criteria, using a standard scoring sheet. We settled any discrepancies by discussion. For each included trial, we extracted information on smoking cessation rates after six months or more, the method of randomization, and whether an intention-to-treat analysis could possibly be done. If the results were not based on an intention-to-treat analysis but drop-outs were recorded, we recalculated the results to include all randomized subjects, with those

lost to follow up assumed to be continuing smokers. We used the strictest criteria for abstinence. Where appropriate, we calculated a pooled odds ratio using the Mantel-Haenszel method. We tested for statistical heterogeneity, and where we found it we made judgements as to its source in the patient population, interventions or outcome assessments.

RESULTS

Description of studies

See: [Characteristics of included studies](#); [Characteristics of excluded studies](#).

We found nine reports ; of trials which qualified for inclusion in this review (see Table: Characteristics of included studies). All of these were English language.

These studies varied greatly in the type of hypnotic induction used and its duration. Three studies ([Barkley 1977](#); [Hyman 1986](#); [Rabkin 1984](#)) mentioned the type of induction used whilst the six remaining studies did not describe the technique. The length of programme varied from a single session ([Rabkin 1984](#); [Williams 1988](#)), two sessions ([Lambe 1986](#)) up to nine weeks ([Fee 1977](#), number of hypnotherapy sessions not described). The total duration of hypnosis administered during the study varied from 30 minutes to 7 hours. Because of this diversity it was not possible to group the studies on the basis of type or duration of hypnosis.

The range of control interventions was broad, with some studies comparing more than one intervention. Three studies compared hypnotherapy with a no-treatment waiting list comparison group ([Lambe 1986](#); [Pederson 1975](#); [Williams 1988](#)). Of the trials which included an alternative intervention arm, four compared hypnotherapy with an attention/advice group. Two of these ([Barkley 1977](#); [Williams 1988](#)) used a control group matched for number of sessions and therapist contact. In the other two ([Hyman 1986](#); [Rabkin 1984](#)) the comparison intervention had a different format. Two studies compared hypnotherapy with non-specific psychological treatments ([Fee 1977](#); [Rabkin 1984](#)) and two with rapid or focused smoking ([Hyman 1986](#); [Barkley 1977](#)).

In three studies ([Pederson 1975](#); [Pederson 1979](#); [Pederson 1980](#)) hypnotherapy was used in conjunction with counselling and compared with counselling alone. In these trials the hypnotherapy took place in one session during a programme of six or more group meetings.

Six randomized studies were excluded because they had less than 6 months follow up ([Casmar 2003](#); [Cornwell 1981](#); [Perry 1979](#); [Schubert 1983](#); [Spanos 1993](#); [Valbo 1995](#)) and three controlled studies were excluded because they were not randomized ([Bastien 1983](#); [Javel 1980](#); [MacHovec 1978](#)).

Risk of bias in included studies

We assessed the quality of study design was based on a) randomization, b) verification of smoking cessation and c) blinding.

a) All of the included studies mentioned randomization but none stated the method in enough detail to assess whether randomization achieved adequate allocation concealment.

b) Studies used a variety of methods to assess smoking cessation at six months or later follow up: two studies (Hyman 1986; Rabkin 1984) measured serum thiocyanate during the study programme but in both cases abstinence at six months was based on self report. The other studies used self report obtained by a personal or telephone interview or by postal questionnaire, or did not state the method of follow up.

c) No studies stated that the outcome assessor was blind to the treatment group of the participants.

Effects of interventions

There was little information on the types of hypnosis used in the studies reviewed, and large variation in the nature of the control interventions. We therefore made no attempt to perform meta-analysis for different forms of hypnosis, or to provide an overall summary estimate of the effectiveness of hypnosis. We made five main comparisons:

1. Hypnosis versus a waiting list/no treatment control
2. Hypnosis versus attention placebo/advice
3. Hypnosis versus psychological treatments
4. Hypnosis versus rapid/focused smoking
5. Hypnosis plus group therapy versus group therapy alone.

Trials with multiple treatment/control arms contributed to more than one comparison. In comparisons 1, 2 and 5 there proved to be significant statistical heterogeneity between the results of the contributing trials, so we did not calculate a pooled odds ratio (OR). The individual trial data are however still displayed graphically in the Summary of Analyses.

In several studies there were control groups in which no participants gave up smoking. In these cases where there are zero cells and small total numbers, the confidence interval calculated around the results of a single trial using the Peto method may be misleading. The Mantel-Haenszel method produces a confidence interval under these conditions which is much wider. Whichever method is used the apparent superiority of hypnosis in these small trials should not be interpreted as statistically confirmed, because of the uncertainty involved in calculating valid confidence intervals.

In **Comparison 1**, of hypnotherapy with a waiting list control, two small trials (Pederson 1975; Williams 1988), with a total of 72 smokers, each reported significantly greater odds of quitting following hypnotherapy. In the larger trial with 180 participants (Lambe 1986) there was no increase in the odds of quitting with hypnotherapy. There was significant heterogeneity between these results (chi squared 7.79, df 2, $P < 0.05$). A possible explanation

for the difference is that after randomization this control group received an initial letter from a physician and a self-help booklet, and three telephone calls during the first three months of follow up which offered encouragement in addition to ascertaining smoking behaviour. This was a minimal intervention compared to the attention/advice control interventions included in Comparison 2, but it was more than was provided to the waiting list controls in the other two studies in Comparison 1. The measure of quitting used in this study was point prevalence rather than sustained abstinence, and the data shows that the proportion of quitters in the control group increased between 3 and 12 months, whilst in the hypnotherapy group it was already high at three months. The authors of this study also note that only 45/90 patients in the hypnotherapy group underwent at least one hypnosis session and that success in the hypnosis group did not appear to be related to receipt of the intervention, although those who actually declined hypnosis were less successful.

Comparison 2, comparing hypnotherapy with attention/advice control groups also had significant heterogeneity (chi squared 9.55, df 3, $P < 0.05$). There were four trials in which the largest (Rabkin 1984) showed no trend towards success of hypnotherapy, compared to a health education lecture and a single follow-up counselling session. A small trial (Hyman 1986) showed no sign of improved quit rates compared with an attention placebo consisting of four discussion group meetings. The two studies (Barkley 1977; Williams 1988) which showed increased odds of quitting with hypnotherapy were small and had zero control group quit rates.

Comparisons 3 and 4, for which pooled ORs were calculated, each included only two small trials. In both cases the pooled OR was close to 1, with confidence intervals which were extremely wide. The results of these limited meta-analyses do not therefore provide adequate evidence as to whether or not hypnotherapy was more or less effective than psychological treatment or rapid smoking.

Of the three trials by Pederson and colleagues in **Comparison 5**, two found a trend towards increased cessation when there was a single session of hypnosis during the counselling programme, whilst one (Pederson 1980), in which rapid smoking was also included in the programme, found the reverse trend. This difference in treatment procedure may be the source of the heterogeneity in these results.

DISCUSSION

Hypnotherapy has not been proven to have a greater effect on six-month quit rates than other interventions, or than no intervention. Those studies which have found higher quit rates compared to no intervention have been small, and had methodological weaknesses. If hypnotherapy can increase the likelihood of quitting compared to no intervention it may be due to non-specific

factors such as contact with a therapist. The absence of a suitable placebo for hypnotherapy to control for the non-specific effects makes evaluation difficult. When hypnosis is compared with other interventions involving therapist contact, group contact or other support, there is no evidence that it is more successful. One problem with these 'head to head' comparisons is that the evidence for the efficacy of other behavioural interventions is equally difficult to evaluate. A Cochrane review of aversive smoking (Hajek 1997) concluded that methodological problems in the trials made it impossible to show whether the technique was effective.

One trial by Pederson and colleagues (Pederson 1979) did include two arms intended to investigate the non-specific elements of hypnotherapy. One group received a hypnosis session which was presented as an aid to relaxation, and the other controlled for the therapist presence by using a video presentation for the hypnotherapy session. These treatment arms have not been included in a comparison; only the full hypnotherapy which included smoking cessation suggestions is used in comparison 5. The other two variants had lower quit rates, similar to the counselling alone control.

Differences between the quit rates of the comparison control or alternative treatment groups could be one explanation for some of the heterogeneity seen in the results. Although a low level of quitting is expected in the general population of smokers even without a specific intervention, in a small trial, random variation alone can explain an observed zero quit rate. This adds to the level of statistical uncertainty due to the small sample size.

The highly significant treatment effects of hypnotherapy on smoking cessation claimed by uncontrolled studies (e.g. Dedenroth 1968) cannot be confirmed from analysis of randomized controlled trials. Encouraging results reported in uncontrolled studies may be due to the motivation of those presenting for treatment, or may not reflect likely long-term success or drop-out rates.

AUTHORS' CONCLUSIONS

Implications for practice

There is insufficient evidence to recommend hypnotherapy as a specific treatment for smoking cessation.

Implications for research

Since hypnotherapy is regularly suggested as a possible aid to smoking cessation there is a need for large trials to establish its efficacy. The type of hypnotherapy used needs to be clearly defined and described. Comparison needs to be made with active interventions, preferably matching for therapist contact time.

ACKNOWLEDGEMENTS

Dr Klaus Linde for comments.

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* Indicates the major publication for the study

CHARACTERISTICS OF STUDIES

Characteristics of included studies [ordered by study ID]

Barkley 1977

Methods	Country: USA Recruitment: advertisements in a university community Randomization: method not specified, stratified by sex	
Participants	36 smokers	
Interventions	a) rapid smoking b) group hypnosis c) attention placebo All treatments had 7 1-hr sessions over 2 weeks	
Outcomes	Self-reported abstinence at 9 months No validation	
Notes	b) vs c) in hypnotherapy compared to attention/advice	
Risk of bias		
Item	Authors' judgement	Description
Allocation concealment?	Unclear	B - Unclear

Fee 1977

Methods	Country: UK Recruitment: Referrals to an anti-smoking clinic Randomization: method not described	
Participants	232 smokers	
Interventions	a) Hypnosis for 9 weeks (method not stated) b) Aversion (covert sensitization) c) Fenfluramine d) Placebo All treatments lasted 9 weeks, number and duration of sessions not stated	
Outcomes	Self-reported abstinence at 12 months No validation	
Notes	a) vs b) in hypnotherapy compared to psychological treatment	
Risk of bias		

Fee 1977 (Continued)

Item	Authors' judgement	Description
Allocation concealment?	Unclear	B - Unclear

Hyman 1986

Methods	Country: Australia Recruitment: half referred through public hospital, half via advertisements Randomization: method not described
Participants	60 smokers
Interventions	a) Hypnosis (Weitzenhoffer & Hilgard induction method, modified Spiegel treatment) b) Focused smoking c) Attention placebo d) Waiting list control All treatment subjects seen individually for 1hr once a week for 4 weeks
Outcomes	Self-reported abstinence (postal questionnaire) at 6 months. No validation at 6 months but serum thiocyanate measured at 3 months. (Waiting list control group followed up for 3 months then offered treatment, so not used in a comparison)
Notes	Subjects were expected to abstain after first session of hypnosis but received all four hypnotic sessions whether they had successfully abstained or not. Used in 2 comparisons: Hypnosis compared to c) for attention/advice, b) for rapid/focused smoking

Risk of bias

Item	Authors' judgement	Description
Allocation concealment?	Unclear	B - Unclear

Lambe 1986

Methods	Country: USA Recruitment: Patients attending a Family Medicine Centre who wished to quit smoking Randomization: method not stated, but Zelen design (18 subjects declined hypnosis but analyzed in hypnosis group)
Participants	180 smokers
Interventions	a) Hypnosis, 2 x 40min sessions (probably individual), 2 weeks apart. Instructions for autohypnosis b) Control - letter from physicians advising quitting, copy of Calling It Quits booklet. All subjects received 3 telephone calls in first 4 months to offer encouragement and ascertain smoking behaviour

Lambe 1986 (Continued)

Outcomes	Self-reported (telephone or questionnaire) abstinence at 12 months No validation	
Notes	Used in no treatment control comparison, but follow-up calls may have helped encourage cessation. Numbers of quitters derived from percentages, corrected for drop-outs.	
Risk of bias		
Item	Authors' judgement	Description
Allocation concealment?	Unclear	B - Unclear

Pederson 1975

Methods	Country: Canada Recruitment: Community volunteers Randomization: method not described, stratified by gender	
Participants	48 smokers	
Interventions	a) Waiting list control (contacted by telephone at 1, 3 and 10 months) b) Counselling (6 weekly group discussions about quitting techniques) c) Hypnosis and counselling (same discussion meetings and 1.5hr session of group hypnosis)	
Outcomes	Self-reported abstinence for at least 3 months at 10 month follow up	
Notes	c) vs a) in waiting list control comparison c) vs b) in comparison of hypnosis plus other therapy vs other therapy alone	
Risk of bias		
Item	Authors' judgement	Description
Allocation concealment?	Unclear	B - Unclear

Pederson 1979

Methods	Country: Canada Recruitment: Community volunteers Randomization: method not described, stratified by sex	
Participants	65 smokers	
Interventions	a) Live hypnosis and counselling b) Videotape hypnosis and counselling c) Relaxation hypnosis plus counselling d) Counselling alone	

Pederson 1979 (Continued)

	All groups received 6 weekly sessions followed by 3 monthly sessions. Hypnosis was used at the third weekly session	
Outcomes	Self-reported abstinence for at least 3 months at 6 months post-treatment No validation	
Notes	a) vs d) in comparison of hypnosis plus other therapy vs other therapy alone	
<i>Risk of bias</i>		
Item	Authors' judgement	Description
Allocation concealment?	Unclear	B - Unclear

Pederson 1980

Methods	Country: Canada Recruitment: Community volunteers Randomization: method not described. Subjects who were not allowed to participate in rapid smoking received hypnosis and counselling alone	
Participants	66 smokers	
Interventions	a) Rapid smoking (3rd session) & hypnosis (4th session) & counselling b) Rapid smoking (3rd session) & counselling c) (Subjects excluded at medical screening from rapid smoking) hypnosis and counselling All groups had 6 weekly sessions followed by 3 monthly sessions	
Outcomes	Self-reported abstinence (telephone contact) for at least 3 months at 6 month follow up	
Notes	a) vs b) in comparison of hypnosis plus other treatment vs other treatment alone	
<i>Risk of bias</i>		
Item	Authors' judgement	Description
Allocation concealment?	Unclear	B - Unclear

Rabkin 1984

Methods	Country: Canada Recruitment: media advertising - community volunteers Randomization: method not described	
Participants	168 smokers	

Rabkin 1984 (Continued)

Interventions	a) Hypnosis - single 30min individual session (Spiegel method and instructions for autohypnosis) b) Behaviour modification - 5 meetings during 3 weeks c) Health education - a single group meeting and one individual counselling session d) Waiting list control (no follow up)	
Outcomes	Self-reported abstinence (questionnaire) at 6 month follow up. No validation at 6 months, serum thiocyanate levels measured post-programme.	
Notes	a) vs b) in comparison with psychological treatment, a) vs c) in comparison with attention/advice. Drop-outs included in denominator.	
Risk of bias		
Item	Authors' judgement	Description
Allocation concealment?	Unclear	B - Unclear

Williams 1988

Methods	Country: USA Recruitment: Via company newsletters Randomization: method not stated	
Participants	60 smokers who had attended at least one other smoking cessation programme, and who worked for one of 3 companies	
Interventions	a) Hypnosis (single 2.5hr group session) using an adaptation of Spiegel procedure. There were two 45min hypnosis trials, followed by a 45 min question period to help subjects understand procedure, alleviate misconceptions and clarify self-monitoring procedure. b) Placebo control (single 2.5hr discussion session) c) No treatment control (self monitoring and 12 month waiting list) Self monitoring of cigarettes smoked was for 7 days prior to treatment and 4, 12, 24 and 48 week follow-up	
Outcomes	Self-reported abstinence at 48 weeks	
Notes	a) vs b) in comparison with attention placebo, a) vs c) in no treatment comparison Participants were told that their companies were sponsoring the programme in the interest of employees' health	
Risk of bias		
Item	Authors' judgement	Description
Allocation concealment?	Unclear	B - Unclear

Characteristics of excluded studies *[ordered by study ID]*

Ahijevych 2000	No control group
Bastien 1983	Controlled trial, but not randomized
Casmar 2003	Follow up only three months
Cornwell 1981	Short follow-up (2 months)
Crasilneck 1968	No control group
Dedenroth 1968	No control group
Frank 1986	All groups received hypnotherapy. Trial was to test combining with other support and varying schedules
Javel 1980	Not randomized (consecutive allocation), short follow-up.
Johnson 1994	No control group
Katz 1978	No control group
MacHovec 1978	Not stated to be randomized
Owens 1981	No control group
Perry 1975	No control group
Perry 1979	No non hypnotherapy control group, short follow-up (3 months)
Richard 2002	Descriptive report, not a controlled trial
Schubert 1983	Short follow up (4 months)
Spanos 1993	Short follow-up
Spiegel 1993	No control group
Valbo 1995	Short follow up (4 months)

DATA AND ANALYSES

Comparison 1. Smoking cessation at 6m+ follow up

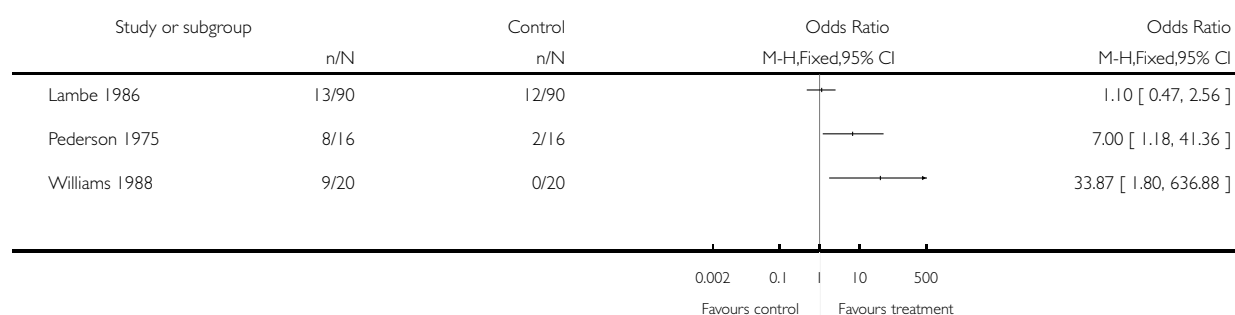
Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Hypnotherapy vs waiting list/no treatment	3		Odds Ratio (M-H, Fixed, 95% CI)	Totals not selected
2 Hypnotherapy vs attention/advice	4		Odds Ratio (M-H, Fixed, 95% CI)	Totals not selected
3 Hypnotherapy vs psychological treatments	2	211	Odds Ratio (M-H, Fixed, 95% CI)	0.92 [0.42, 2.02]
4 Hypnotherapy vs rapid/focused smoking	2	54	Odds Ratio (M-H, Fixed, 95% CI)	1.0 [0.32, 3.11]
5 Hypnotherapy plus other therapy vs other therapy alone	3		Odds Ratio (M-H, Fixed, 95% CI)	Totals not selected

Analysis 1.1. Comparison 1 Smoking cessation at 6m+ follow up, Outcome 1 Hypnotherapy vs waiting list/no treatment.

Review: Hypnotherapy for smoking cessation

Comparison: 1 Smoking cessation at 6m+ follow up

Outcome: 1 Hypnotherapy vs waiting list/no treatment

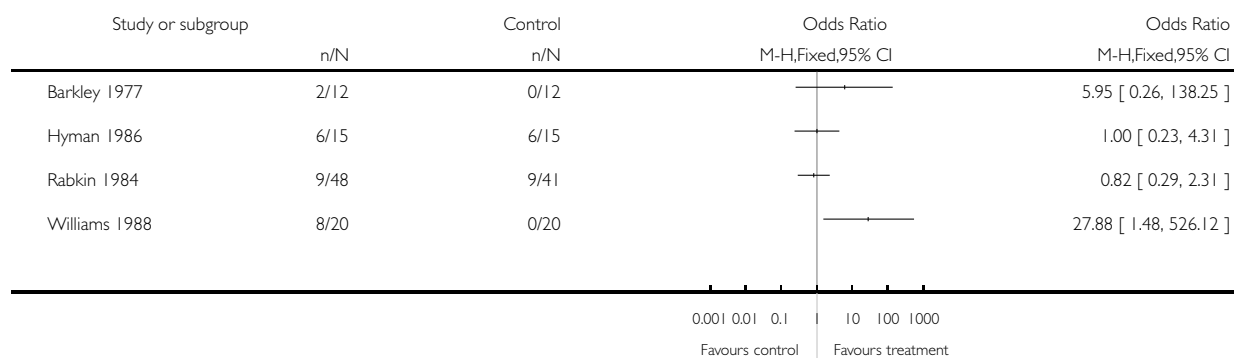


Analysis 1.2. Comparison 1 Smoking cessation at 6m+ follow up, Outcome 2 Hypnotherapy vs attention/advice.

Review: Hypnotherapy for smoking cessation

Comparison: 1 Smoking cessation at 6m+ follow up

Outcome: 2 Hypnotherapy vs attention/advice

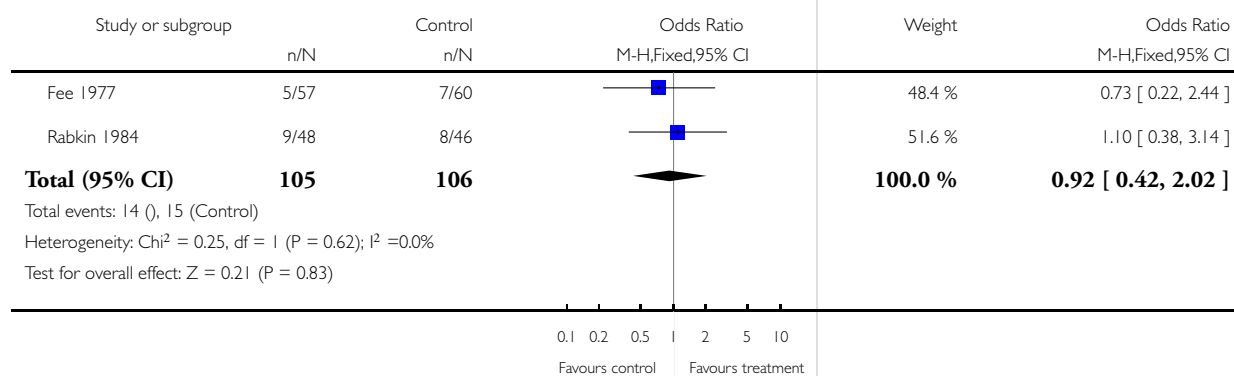


Analysis 1.3. Comparison 1 Smoking cessation at 6m+ follow up, Outcome 3 Hypnotherapy vs psychological treatments.

Review: Hypnotherapy for smoking cessation

Comparison: 1 Smoking cessation at 6m+ follow up

Outcome: 3 Hypnotherapy vs psychological treatments

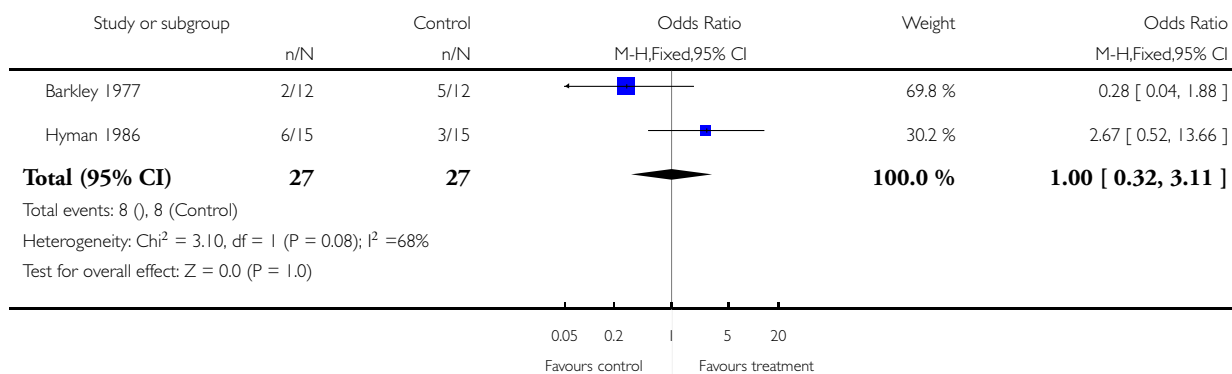


Analysis 1.4. Comparison 1 Smoking cessation at 6m+ follow up, Outcome 4 Hypnotherapy vs rapid/focused smoking.

Review: Hypnotherapy for smoking cessation

Comparison: 1 Smoking cessation at 6m+ follow up

Outcome: 4 Hypnotherapy vs rapid/focused smoking

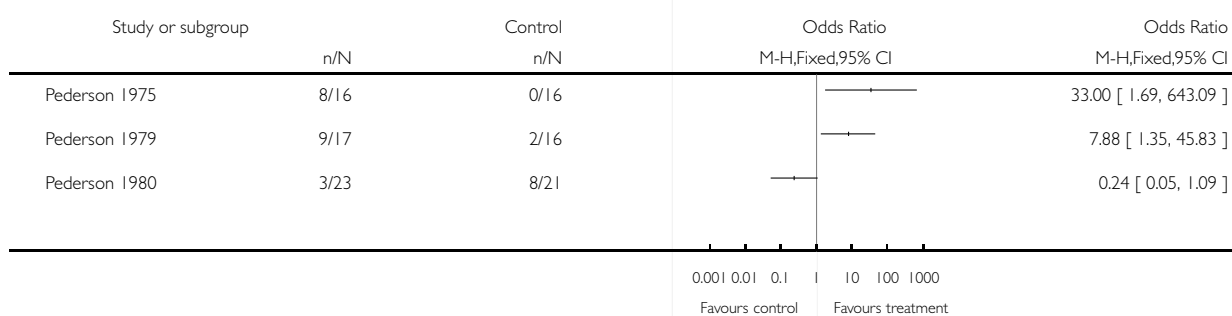


Analysis 1.5. Comparison 1 Smoking cessation at 6m+ follow up, Outcome 5 Hypnotherapy plus other therapy vs other therapy alone.

Review: Hypnotherapy for smoking cessation

Comparison: 1 Smoking cessation at 6m+ follow up

Outcome: 5 Hypnotherapy plus other therapy vs other therapy alone



FEEDBACK

Hypnotherapy versus NRT or bupropion

Summary

The comment asked whether anyone knew of any formal comparisons of hypnotherapy with treatments such as NRT or bupropion

Reply

We know of no randomized controlled trials comparing hypnotherapy with NRT or bupropion (Zyban) but we eagerly await such reports. We agree that it is important to compare different methods of smoking cessation. At the moment, only nine trials have been identified, and overall these have not shown that hypnotherapy has a greater effect on six-month quit rates than other interventions or indeed no treatment. The small number of trials and their heterogeneity mean, however, that the jury is still out, and further data from adequately powered randomized studies is urgently needed.

Contributors

Neil Abbot

Losses to follow up

Summary

The commenter asked whether the estimates changed significantly if those lost to follow up were excluded rather than counted as continuing smokers

Reply

This contribution raises an interesting and important point. The inclusion or otherwise of those lost to follow-up is the concern of intention to treat analysis (ITT) which is comprehensively discussed in Section 8.4 of the Reviewer's handbook (available on the web at <http://www3.interscience.wiley.com/homepages/106568753/handbook.pdf>).

The ideal strategy is to compare the groups exactly as randomised, but if data on some participants are lost for a variety of reasons, this can be impossible. ITT analysis aims to include all participants randomized into a trial irrespective of what happened subsequently. ITT analyses are generally preferred as they are unbiased, and also because they address a more pragmatic and clinically relevant question. It is the view of the Collaboration that ITT analysis delivers the most robust evidence and is to be preferred over less conservative approaches, and it explicitly adopts this approach in its reviews wherever possible.

In the case of smoking cessation, the convention is to treat patients lost to follow-up as continuing smokers. Some people may consider this inappropriate since we may be attributing the continuation of smoking to people who have actually quit. However, first, we are dealing here with randomised trials with a hypnotherapy and a control intervention, and this assumption is made for both the treatment and the control arms of each study, so it is thus unlikely that the use of ITT will adversely affect the treatment arm compared with the control arm. Second, the decision to assume that those lost to follow-up are continuing smokers is based on clinical judgement as to what would be the most likely outcome, and most professionals would agree that this assumption is not unreasonable.

Ideally, we would compute both ways, i.e. assuming that those lost to follow up were, first, continuing smokers and then, second, quitters, and perform a sensitivity analysis. Another option would be to analyse as you have suggested, using only the available data, i.e. excluding losses to follow up. Of the nine included studies in the current review, four only present an ITT analysis with insufficient information to perform an available-data analysis (the Pederson studies and the Williams trial). None of the remaining five studies achieves a statistically significant result by excluding dropouts and those lost to follow up. The main impact of the analysis is to reduce the precision of the estimates by widening the confidence intervals. We continue to abide by the guidance of the Cochrane Collaboration convention, and present the outcomes on an intention to treat basis where possible, as they are currently displayed in the review.

Contributors

Neil Abbott

WHAT'S NEW

Last assessed as up-to-date: 15 February 2005.

19 June 2008	Amended	Converted to new review format.
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HISTORY

Protocol first published: Issue 1, 1998

Review first published: Issue 2, 1998

22 May 2005	Amended	Response to Feedback included
16 February 2005	New search has been performed	Updated for 2005 Issue 2. Four references added to Excluded studies (Bastien 1983, Casmar 2003, Frank 1986, Richard 2002)
16 February 2005	Amended	Response to Feedback included
5 August 2001	New search has been performed	Updated for 2001 Issue 4. No new studies identified.

CONTRIBUTIONS OF AUTHORS

NA initiated the review and identified studies and extracted data, and updates the review. AW & JB assisted with data extraction. LS helped identify studies, extract data and update the review.

DECLARATIONS OF INTEREST

None

SOURCES OF SUPPORT

Internal sources

- University of Dundee, Department of Medicine, UK.
- Department of Primary Health Care, Oxford University, UK.

External sources

- Wellcome Trust, UK.
- NHS Research and Development National Cancer Programme, England, UK.

NOTES

From 2006 Issue 4 Joanne Barnes becomes the new contact author, and Neil Abbot remains as a co-author of this review.

INDEX TERMS

Medical Subject Headings (MeSH)

*Hypnosis; Smoking [*prevention & control]; Smoking Cessation [*methods]

MeSH check words

Humans