

The Science of Hypnosis: What Do We Know Today? A Narrative Review

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Abstract

This narrative review synthesises evidence on the clinical effectiveness of hypnosis across medical and psychological settings, including pain management, procedural distress, gastrointestinal disorders and mental health care. Following a structured PubMed search with a cut-off of 31 December 2025, 87 reports underwent full-text assessment, of which 82 were included in the synthesis. In the descriptive classification presented in Appendix A, 59 reviews (72.0%) report positive findings, 6 (7.3%) do not confirm effectiveness and 17 (20.7%) are inconclusive. These proportions describe review-level classifications and do not represent pooled treatment effects. Neuroimaging studies associate hypnosis with changes in networks involved in attention, emotional regulation and sensory processing, although findings vary across tasks and participants. Available safety data are reassuring in the medical settings studied, but adverse-event reporting is incomplete and does not establish safety across all psychiatric populations. Variation in hypnotic protocols, study methods and review scope limits the strength and generalisability of the conclusions. Hypnosis may be a useful adjunct to established treatments in selected clinical contexts; its application should reflect the evidence for the specific indication.

clinical trials, hypnosis, review

INTRODUCTION

Hypnosis has long been a subject of both scientific inquiry and public fascination. Over the past century, its conceptualisation has evolved from early, speculative theories towards increasingly sophisticated models grounded in experimental psychology and the neurosciences.

According to the American Psychological Association, hypnosis is defined as a state of focused attention accompanied by reduced peripheral awareness and an enhanced capacity to respond to suggestion [1]. This definition highlights two central aspects of the hypnotic state: alterations in attentional processes and the heightened influence of cognitive and sensory modulation [2]. Both features have direct implications for clinical practice, particularly in the management of pain, anxiety, and stress-related symptoms.

Across medical and psychological settings, clinicians frequently encounter patients whose distress, anticipatory anxiety or maladaptive beliefs amplify symptoms and impede cooperation [3]. Hypnosis may address these difficulties by sup-

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porting reduced reactivity to stressors, greater tolerance of discomfort and engagement with therapeutic change. Its collaborative nature may also support trust and an active role for the patient in treatment [4].

Despite persistent misconceptions rooted in some areas of popular culture, empirical research over the last several decades shows that hypnotic interventions can meaningfully reduce pain, anxiety and somatic symptoms, while complementing existing psychotherapeutic and medical treatments [5–7]. However, findings remain widely dispersed across specialties such as oncology, gastroenterology, anaesthesiology, paediatrics and psychotherapy, making it difficult for practitioners to appreciate the broader landscape of evidence [8–10].

This narrative review aims to synthesise this diverse literature and clarify how understanding of the clinical effectiveness and mechanisms of hypnosis has evolved. By integrating findings from 82 reviews, it provides a structured overview of the evidence across clinical domains and stages of scientific development. These reviews collectively describe more than 900 studies, but overlap between reviews means that this figure should not be interpreted as the number of unique studies.

Growth of Hypnosis Research

Scientific interest in hypnosis has evolved over more than a century, particularly within the field of mental health, reflecting shifts in psychological theory, research methodology and clinical practice [11]. Early work at the turn of the twentieth century was largely descriptive and theoretical, grounded in the emerging fields of psychiatry, suggestibility research and psychophysiology [12]. For several decades, scientific exploration was sporadic, and hypnosis remained largely confined to isolated case reports, psychoanalytic interpretations and experimental demonstrations [13]. A substantial shift occurred in the 1960s, when advances in experimental psychology and the rise of cognitive science led to renewed interest in studying hypnotic phenomena through controlled laboratory designs [14, 15]. This period marked the beginning of a more rigorous empirical tradition, with researchers increasingly treating hypnosis as a legitimate subject for systematic investigation rather than as a fringe or anecdotal technique [16]. The development of hypnosis research has varied across clinical domains, with some areas generating a substantial body of empirical research, while

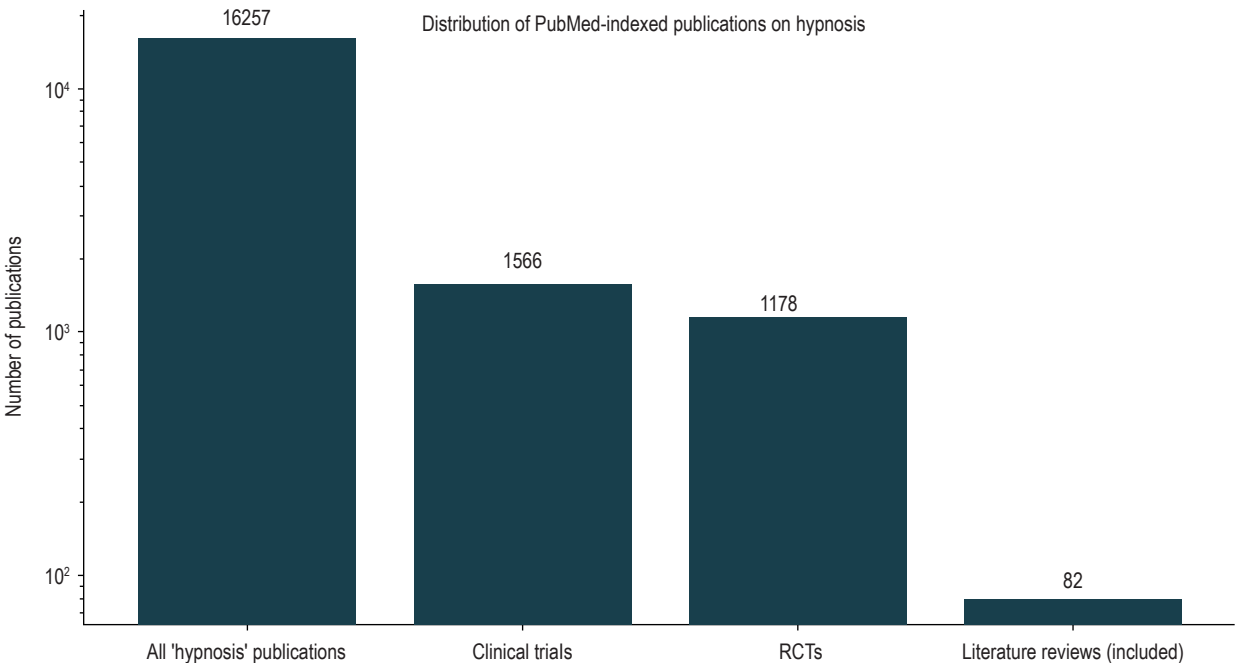


Figure 1. Distribution of hypnosis-related publications indexed in PubMed. The reported search retrieved 16,257 publications, including 1,566 clinical trials and 1,178 randomised controlled trials; 82 reviews were included in this narrative synthesis. The vertical axis is logarithmic, and the categories are not mutually exclusive.

others have followed more descriptive or case-based approaches.

The broad PubMed search reported for this review retrieved 16,257 publications containing the term “hypnosis”. More focused searches identified 1,566 clinical trials, including 1,178 randomised controlled trials (RCTs). Figure 1 presents these counts alongside the 82 reviews included in the narrative synthesis. The categories overlap and should not be summed. Although the studies vary substantially in methodological quality, population characteristics and intervention protocols, the accumulated literature reflects sustained efforts to evaluate hypnosis empirically.

Literature Search and Selection

This narrative review draws on a structured PubMed search covering January 1995 to 31 December 2025. The search used combinations of the terms hypnosis, clinical hypnosis, hypnotherapy, systematic review and meta-analysis. The eligibility criteria were peer-reviewed publications in English involving human participants. Eligible publications included systematic reviews, meta-analyses and review articles synthesising RCTs. Studies focusing on stage hypnosis or non-clinical applications were excluded. As shown in Figure 2, 312 records were identified and screened; 225 were excluded, leaving

87 reports for full-text assessment. Five reports were subsequently excluded because their broad scope did not focus on clearly defined clinical domains. The remaining 82 reviews formed the basis of the synthesis. Figure 2 provides a schematic overview of the selection process.

Clinical Applications of Hypnosis

Research has examined hypnosis across a wide range of clinical applications. The 82 reviews included in this narrative synthesis provide an overview of these domains. The descriptive classification in Appendix A comprises 59 reviews (72.0%) with positive findings, 6 (7.3%) that do not confirm effectiveness and 17 (20.7%) with inconclusive findings. These categories reflect review-level conclusions across different outcomes and populations; they are not estimates of treatment response or pooled efficacy. The evidence is summarised below by clinical area, with a detailed listing in Appendix A, Table A1.

Pain-Related and Procedural Applications

Pain is among the most extensively studied applications of hypnosis. Of the 13 reviews grouped in this domain, 10 (76.9%) are classified as reporting positive findings and three as inconclusive or not confirming effectiveness.

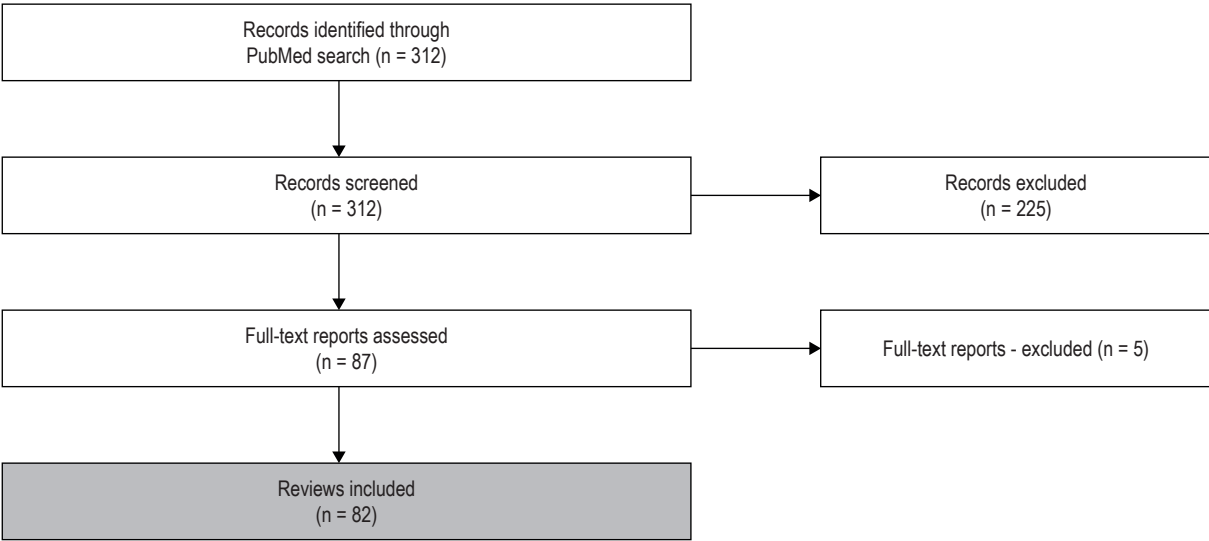


Figure 2. Overview of identification and selection. Of 312 records screened, 225 were excluded. The full texts of 87 reports were assessed, five were excluded and 82 reviews were included.

The review of disability-related pain identified substantial methodological heterogeneity, small samples and inconsistent outcome measures [17]. The review of chronic pelvic pain also highlighted limitations in the evidence base, including study quality and variation in hypnotic protocols [18]. A recent meta-analysis by Jones et al. examined hypnosis primarily as an adjunct to other interventions and reported low certainty of evidence [19]. These limitations constrain conclusions about the magnitude and reliability of benefit in specific pain populations.

A meta-analysis of clinical pain reported reductions in pain across several medical contexts [20]. Benefits have also been investigated in procedural settings. In dental care, hypnosis has been evaluated for acute dental and maxillofacial pain [21]. Perioperative studies have examined preoperative distress, physiological responses, postoperative pain and analgesic requirements [22]. Reviews of diagnostic, therapeutic and minimally invasive procedures have assessed related outcomes, including pain and procedural distress [23, 24]. Research on burn wound care has also reported reductions in pain and anxiety during wound cleaning and dressing changes [10]. Of the 12 reviews grouped under procedural applications in Appendix A, 10 (83.3%) are classified as positive and two as inconclusive. The applicability of these findings depends on the procedure, intervention and comparator.

Pregnancy, Labour and the Perinatal Period

Ten included reviews address pregnancy, labour and the perinatal period. Several report that hypnotic interventions may reduce labour-related pain or anxiety and improve aspects of the childbirth experience [25–27]. In some studies, prenatal hypnosis programmes were associated with less use of pharmacological analgesia and, in some cases, shorter labour. These findings suggest a possible role in supporting relaxation, attentional focus and coping, although benefits are not consistent across outcomes or studies.

Evidence concerning prevention of postnatal depression is insufficient. The Cochrane review by Sado et al. included one study involving 63

women, but it provided no analysable data on the outcomes of interest. The review therefore could not establish whether hypnosis prevents postnatal depression [28].

Other perinatal findings are also mixed. Reviews of guided imagery for hypertension in pregnancy and hypnosis for pain management during labour report limitations in the available evidence [29, 30]. Differences in protocols, timing, session frequency and outcome measures complicate interpretation. Inconclusive findings do not establish either benefit or lack of benefit.

Overall, hypnosis may be a useful non-pharmacological adjunct to standard perinatal care for selected outcomes. Of the 10 reviews in this domain, five (50.0%) are classified as positive; the remaining five are inconclusive or do not confirm effectiveness. Further research is needed before benefits can be generalised across pregnancy, childbirth and the postnatal period.

Psychosomatic Disorders

Hypnosis has been investigated in disorders involving interactions among cognitive, emotional and autonomic processes. Irritable bowel syndrome (IBS) is the most extensively studied condition in this group. A meta-analysis reported improvements in IBS symptoms, while variation in intervention characteristics influenced the findings [8]. Some studies have also reported persistence of benefits at follow-up. The reviews differ in diagnostic criteria, treatment duration and outcome measures [31, 32]. In the descriptive classification in Appendix A, nine of the 11 IBS reviews (81.8%) are positive and two are inconclusive. These counts should be interpreted in the context of variation in review methods and the outcomes assessed.

The literature on functional dyspepsia extends the study of hypnosis to another disorder of gut–brain interaction. A review by Popa et al. examined potential benefits for symptom severity, gastric discomfort and quality of life [33]. The evidence base is smaller than that for IBS. Proposed mechanisms include altered visceral perception, autonomic regulation and cognitive-emotional processing, but these mechanisms should not be regarded as established explanations for treatment response in all patients.

Together, the IBS and functional dyspepsia literature suggests a role for further evaluation of gut-directed hypnotherapy.

Autonomic arousal, attention to internal sensations and stress-related symptom amplification are also relevant to sleep disturbances, another area in which hypnosis has been studied. The clinical evidence for sleep outcomes therefore warrants consideration alongside other psychophysiological applications.

Two of the three included sleep reviews (66.7%) are classified as positive, reporting improvements in outcomes such as sleep quality, sleep onset latency or insomnia severity [9, 34]. The third review reported mixed findings [35]. Differences in outcome definitions and treatment protocols limit comparisons. Relaxation and imagery are common components of these interventions, but further trials are needed to establish which patients and sleep outcomes are most likely to benefit.

Taken together, these findings suggest that hypnosis may help selected patients with symptoms influenced by stress, autonomic arousal and cognitive-emotional factors. IBS, functional dyspepsia and sleep disturbances provide distinct clinical contexts in which attentional control and the modulation of internal sensory experience have been investigated. The proposed overlap in mechanisms does not establish equivalent efficacy across conditions. Additional reviews are listed in Appendix A, Table A1.

Hypnosis in Oncology and Supportive Cancer Care

The oncology literature presents a mixed but generally encouraging picture. Reviews report potential benefits for anxiety, pain, procedural distress and treatment-related symptoms. A systematic review in breast cancer care examined preoperative anxiety and procedure-related discomfort [36], while another synthesis assessed pain and anxiety across oncological settings [37]. Hypnosis has also been evaluated for chemotherapy-induced nausea and vomiting, with positive findings in some studies [38].

Evidence is more limited in palliative settings. A review of end-of-life care found insufficient evidence for firm conclusions, citing small samples, heterogeneous interventions and few high-

quality trials [39]. Rajasekaran et al. similarly reported that methodological weaknesses prevented reliable evaluation in terminally ill patients [40]. Six of the eight adult oncology reviews (75.0%) are classified as positive in Appendix A, while two do not confirm effectiveness. Insufficient evidence should be distinguished from evidence that an intervention has no effect.

Two of the three paediatric oncology reviews (66.7%) are classified as positive and report benefits for procedural pain or distress [41, 42]. The review by Wild and Espie is classified as not confirming effectiveness in Appendix A [43]. Interpretation is limited by the number and quality of available studies. Clinical literature also describes hypnotic responsiveness in children [44], but individual differences remain relevant when selecting and delivering interventions.

Collectively, the evidence suggests that hypnosis may offer support during cancer care, particularly for procedure-related anxiety, treatment-associated pain and nausea. The strength of evidence varies by setting and outcome. An overview of the oncology reviews is provided in Appendix A, Table A1.

Mental Health Applications

Evidence in mental health is heterogeneous, although several applications show promise. A meta-analysis reported reductions in depressive symptoms following hypnosis [45]. Related evidence includes assessments of depressive symptoms in patients with fibromyalgia [46] and an updated meta-analysis of hypnosis as an adjunct to cognitive behavioural therapy (CBT) [47]. These bodies of evidence address different populations and treatment packages and should not be treated as interchangeable estimates of efficacy for depressive disorders.

The literature on anxiety is mixed. One meta-analysis reported reductions in anxiety symptoms following hypnosis [48], while another review highlighted insufficient or heterogeneous evidence across anxiety and phobic disorders [49]. Studies of perceived stress also vary in their findings, intervention protocols and methodological quality [50]. This variability limits firm

conclusions about effectiveness across all anxiety- and stress-related presentations.

Two meta-analyses included in Appendix A reported improvements in post-traumatic stress disorder (PTSD) symptoms following hypno-therapeutic interventions [51, 52]. These findings suggest potential benefit, but the evidence should be interpreted in light of differences in treatment content, populations and study quality. They do not establish that hypnosis can replace established trauma-focused treatments.

Evidence for schizophrenia remains insufficient. The 2004 Cochrane review and its 2007 update concluded that the available trials were too limited to determine whether hypnosis offers measurable benefit [53, 54]. These publications represent versions of the same review and should not be interpreted as independent bodies of evidence.

Of the 13 reviews grouped under mental health applications in Appendix A, nine (69.2%) are classified as positive and four as inconclusive. This group also includes work on hypnosis as an adjunct to CBT, weight management and depressive symptoms in fibromyalgia; the count is therefore broader than evidence specifically concerning psychiatric diagnoses. Findings suggest possible adjunctive benefits in some depressive, anxiety and trauma-related presentations, while other indications remain uncertain. The detailed scope of each entry is shown in Appendix A, Table A1.

Neurological Conditions

Hypnosis has been explored in functional neurological disorder [55] and multiple sclerosis [56, 57]. The available literature describes potential benefits for symptoms, coping and functioning, particularly as part of broader care. However, study designs and outcomes differ, and small samples limit the strength of conclusions. These findings support further investigation of hypnosis in neurological care rather than a general claim of established effectiveness.

Broader Evidence Syntheses and Areas with Limited or Inconclusive Findings

Broader syntheses have also evaluated hypnosis across multiple clinical domains. A review of the efficacy, safety and applications of medical hypnosis described benefits in several settings, including pain and procedural distress, while emphasising limitations in the evidence [58]. Such overviews help identify promising applications, but their conclusions remain dependent on the quality, scope and potential overlap of the underlying studies.

Smoking cessation is an area with mixed findings. Three successive Cochrane reviews reported inconclusive evidence [59–61]. As updates within one review series, they should not be regarded as independent replications. A more recent review by Ekanayake and Elkins reported positive findings in approximately two-thirds of the studies examined [62]. Variation in outcome measurement and intervention delivery, together with the need for biologically verified abstinence, limited the strength of its conclusions.

Of the four smoking cessation reviews included in Appendix A, one (25.0%) is classified as positive and three as inconclusive. More rigorous trials with clearly specified interventions and objective abstinence outcomes are needed to clarify the effectiveness of hypnosis for this indication.

Safety has also been examined. Bollinger analysed adverse-event data from hypnosis trials registered on ClinicalTrials.gov [63]. No serious adverse events were judged likely attributable to hypnosis, and the reported rate of other adverse events was 0.47%. However, several eligible trials did not report adverse-event data, and reporting practices varied substantially. The analysed studies concerned symptoms associated with medical conditions or procedures, limiting generalisation to psychiatric treatment.

Across clinical domains, the evidence is uneven in quality and scope. Available safety findings are reassuring for the settings studied, but incomplete reporting and limited population coverage prevent a universal conclusion that hypnosis is free of risk. Uncertainty about efficacy in a particular indication should be considered separately from evidence concerning safety.

Mechanisms of Hypnosis: Neurophysiological and Cognitive Foundations

Neuroimaging research associates hypnosis with changes in brain activity relevant to attention, sensory processing and emotional experience. These observations are compatible with the definition of hypnosis as focused attention, reduced peripheral awareness and increased responsiveness to suggestion. Findings from functional magnetic resonance imaging (fMRI), positron emission tomography (PET), electroencephalography (EEG) and single-photon emission computed tomography (SPECT) offer complementary perspectives, but they do not establish a single neural signature shared by all hypnotic states.

Studies have reported changes in limbic and paralimbic regions, including the amygdala, anterior cingulate cortex (ACC) and insula, which contribute to emotional processing and interoceptive awareness [64]. Reduced activity in some tasks may be consistent with lower distress or changes in the affective component of pain. The direction and location of these changes depend on the task, suggestions and participants; a uniform reduction in limbic activity should not be assumed.

Prefrontal and frontoparietal networks have also been implicated in hypnotic tasks [64, 65]. Changes in their activity or connectivity may relate to attention and the modulation of sensory input. However, findings do not uniformly indicate increased executive control. The relationship between hypnosis, focused attention and responsiveness to suggestion is likely to depend on the experimental context and individual hypnotic responsiveness.

Altered sensory processing is particularly relevant to hypnotic analgesia. An activation likelihood estimation (ALE) meta-analysis identified a cortical network involving the ACC, cingulate gyrus and insula, together with deactivation in medial thalamic regions [66]. Such findings are consistent with modulation of both sensory and affective aspects of pain. They describe associations during experimental tasks rather than proof of a single mechanism underlying all clinical effects.

Mental imagery may also contribute to hypnotic experiences. A meta-analytic exploration

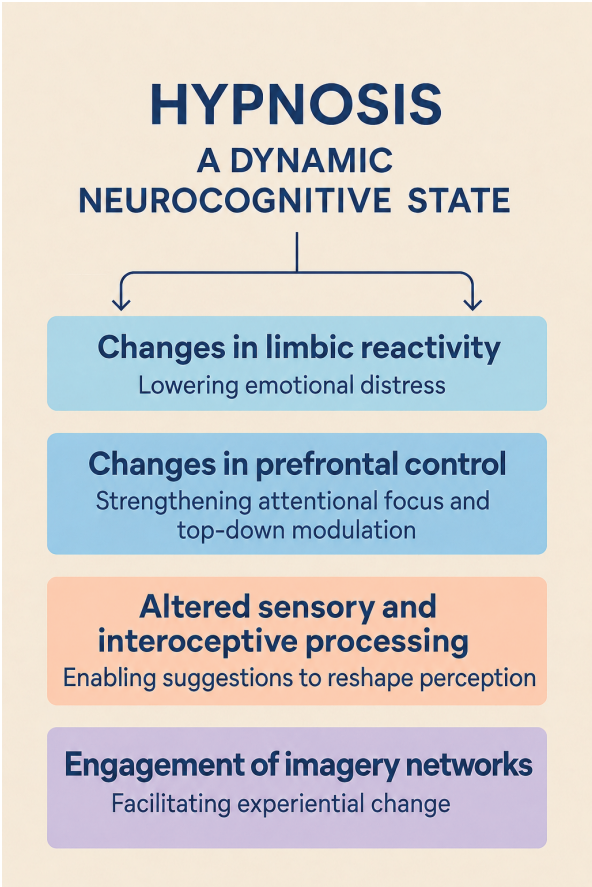


Figure 3. Conceptual illustration of neurocognitive processes investigated in hypnosis research. The direction and magnitude of reported changes vary across tasks, suggestions and participants. These processes are not established as universal features of hypnosis or as causal mechanisms of clinical improvement.

implicated the lingual gyrus, a region involved in visual processing and imagery [65]. This supports investigation of internally generated representations as one component of hypnosis. It does not, by itself, establish that greater imagery vividness mediates clinical improvement across conditions.

Together, these findings support a view of hypnosis as a dynamic neurocognitive process involving several interacting systems. Figure 3 presents a conceptual illustration of four proposed processes: changes in limbic reactivity, prefrontal regulation, sensory and interoceptive processing, and imagery-related activity. The graphic is a schematic model; the direction and consistency of these processes vary across studies, and the four components have not been established as universal mechanisms.

Hypnosis in Psychotherapy and the Ericksonian Approach

Hypnosis also has a role in psychotherapeutic practice. The Ericksonian approach conceptualises it as an experiential process that can be facilitated within therapy. It emphasises individualised and often indirect communication, the activation of personal resources, and the use of metaphor and imagery [67, 68]. This framework informs clinical practice, while evidence for specific techniques requires evaluation in the populations and settings in which they are used.

Meta-analyses suggest that adding hypnosis to CBT can improve outcomes in some contexts [47, 69]. The size and consistency of benefit vary across conditions and study designs. Proposed explanations include greater engagement with cognitive and experiential processes, but these mechanisms should be distinguished from demonstrated treatment effects.

Rapport, trust and collaboration are important considerations in hypnotic work [70]. Responsiveness may be influenced by the therapeutic context, expectations and willingness to engage, as well as individual characteristics. Establishing a shared understanding of treatment and a collaborative relationship is therefore a relevant part of clinical practice.

Psychotherapeutic applications highlight the potential of hypnosis to complement established treatment models through experiential work, emotional regulation and the use of coping resources. The evidence supporting its addition should be assessed for the particular clinical indication.

Limitations

This narrative review synthesises published reviews rather than formally assessing the quality of individual primary studies. Its conclusions therefore depend on the scope and methodological limitations of the included publications. Interventions differ in hypnotic protocols, practitioner training, diagnostic criteria and outcome measures. The descriptive classification of reviews as positive, non-confirmatory or inconclusive does not account for effect size, certainty of evidence or differences among outcomes.

Several areas, including schizophrenia, smoking cessation, stress interventions and some sleep outcomes, have limited or inconsistent evidence. Neuroimaging studies often involve modest samples, and differences in hypnotic responsiveness constrain generalisability. In addition, reviews may share primary studies, and successive updates of some Cochrane reviews are included as separate publications. Review counts therefore do not represent independent replications, and the aggregate study count may contain overlap.

Several cited meta-analyses include primary studies conducted decades ago, in some cases in the mid-twentieth century. Diagnostic frameworks, methodological standards and treatment settings differed substantially from contemporary practice. Findings from these studies may have limited applicability to current clinical populations.

A narrative synthesis can help organise this dispersed literature, but it cannot replace indication-specific assessments of efficacy and safety. The findings should be read as an overview of reported evidence and areas requiring further investigation. More rigorous trials with clearly specified interventions, active controls and systematic adverse-event reporting would strengthen future conclusions.

CONCLUSIONS

Hypnosis may be a useful adjunct in selected medical and psychological settings, particularly for some pain, procedural distress and gastrointestinal outcomes. Evidence concerning perinatal care, oncology and mental health varies by indication and outcome. Neuroimaging findings suggest involvement of attention, emotional processing and sensory modulation, while substantial heterogeneity limits claims about universal mechanisms.

The 82 included reviews support continued evaluation and selective, evidence-informed use of hypnosis alongside established treatments. Available safety data are reassuring in the medical settings studied but are incomplete, particularly for psychiatric populations. Clinical decisions should reflect the quality of evidence for the specific indication, patient preferences and

practitioner competence. Better studies and clearer reporting are needed to define the benefits, limitations and risks of hypnosis across settings.

The authors presented work on this topic at the XXII World Congress of Medical and Clinical Hypnosis, “Cooperation in Hypnosis: Challenges & Benefits”, held on 12–15 June 2024 in Kraków, Poland.

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APPENDIX A

The Science of Hypnosis: What Do We Know Today?
A Narrative Review

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Reference numbers in Table A1 refer to the independent reference list at the end of this appendix.

Table A1. Summary of the included reviews and their reported findings.

Clinical area	Authors and year	Ref.	Positive findings	Does not confirm effectiveness	Inconclusive findings
PAIN-RELATED APPLICATIONS					
	Adachi et al. 2014	[1]	X		
	Bernardy et al. 2011	[2]	X		
	Coitinho Biurra et al. 2023	[3]		X	
	Bowker and Dorstyn 2016	[4]			X
	Flynn 2018	[5]	X		
	Jensen and Patterson 2006	[6]	X		
	Jones et al. 2024	[7]			X
	Langlois et al. 2022	[8]	X		
	Milling et al. 2021	[9]	X		
	Montgomery et al. 2000	[10]	X		
	Rosendahl et al. 2023	[11]	X		
	Thompson et al. 2019	[12]	X		
	Yerzhan et al. 2025	[13]	X		
MEDICAL PROCEDURES					
Medical procedures	Cheseaux et al. 2014	[14]			X
Medical procedures	Holler et al. 2021	[15]	X		
Medical procedures	Lahoud et al. 2026*	[16]			X
Medical procedures	Montgomery et al. 2002	[17]	X		
Medical procedures	Noergaard et al. 2019	[18]	X		

Clinical area	Authors and year	Ref.	Positive findings	Does not confirm effectiveness	Inconclusive findings
Medical procedures	Schnur et al. 2008	[19]	X		
Medical procedures	Tefikow et al. 2013	[20]	X		
Medical procedures	Walter et al. 2025	[21]	X		
Dentistry	Silva et al. 2025	[22]	X		
Dentistry	Jugé and Tubert-Jeannin 2013	[23]	X		
Dentistry	Merz et al. 2022	[24]	X		
Burns	Provençal et al. 2018	[25]	X		
PREGNANCY, LABOUR AND THE PERINATAL PERIOD					
	Catsaros and Wendland 2020	[26]	X		
	Catsaros and Wendland 2023	[27]	X		
	Cyna et al. 2004	[28]	X		
	Dumont et al. 2023	[29]	X		
	Fernández-Gamero et al. 2024	[30]	X		
	Haruna et al. 2019	[31]			X
	Lai et al. 2024	[32]		X	
	Madden et al. 2016	[33]			X
	Nishi et al. 2014	[34]		X	
	Sado et al. 2012	[35]			X
PSYCHOSOMATIC DISORDERS					
IBS	Adler et al. 2025	[36]	X		
IBS	Gholamrezaei et al. 2006	[37]	X		
IBS	Hefner et al. 2009	[38]			X
IBS	Krouwel et al. 2021	[39]	X		
IBS	Lee et al. 2014	[40]	X		
IBS	Peters et al. 2015	[41]	X		
IBS	Rutten et al. 2013	[42]	X		
IBS	Schaefer et al. 2014	[43]	X		
IBS	Webb et al. 2007	[44]			X
IBS	Whitehead 2006	[45]	X		
IBS	Wilson et al. 2006	[46]	X		
Dyspepsia	Popa et al. 2019	[47]	X		
Sleep disorders	Chamine et al. 2018	[48]	X		
Sleep disorders	Lam et al. 2015	[49]			X
Sleep disorders	Wofford et al. 2023	[50]	X		
Psychosomatics	Flammer and Alladin 2007	[51]	X		
ONCOLOGY AND SUPPORTIVE CANCER CARE					
Oncology	Chen et al. 2017	[52]	X		
Oncology	Cramer et al. 2015	[53]	X		

Clinical area	Authors and year	Ref.	Positive findings	Does not confirm effectiveness	Inconclusive findings
Oncology	Franch et al. 2023	[54]	X		
Oncology	Montgomery et al. 2017	[55]		X	
Oncology	Rajasekaran et al. 2005	[56]		X	
Oncology	Richardson et al. 2007	[57]	X		
Oncology	Sine et al. 2022	[58]	X		
Oncology	Zeng et al. 2022	[59]	X		
Paediatric oncology	Nunns et al. 2018	[60]	X		
Paediatric oncology	Richardson et al. 2006	[61]	X		
Paediatric oncology	Wild and Espie 2004	[62]		X	
MENTAL HEALTH APPLICATIONS					
Obesity / weight management	Allison and Faith 1996	[63]	X		
Adjunct to CBT	Kirsch et al. 1995	[64]	X		
Obesity / weight management	Kirsch 1996	[65]	X		
Adjunct to CBT	Ramondo et al. 2021	[66]	X		
Depression	Shih et al. 2009	[67]	X		
Fibromyalgia	Zech et al. 2017	[68]	X		
Anxiety	Pelissolo 2016	[69]			X
Anxiety	Valentine et al. 2019	[70]	X		
PTSD	O'Toole et al. 2016	[71]	X		
PTSD	Rotaru and Rusu 2016	[72]	X		
Schizophrenia	Izquierdo de Santiago and Khan 2004	[73]			X
Schizophrenia	Izquierdo de Santiago and Khan 2007	[74]			X
Stress	Fisch et al. 2017	[75]			X
NEUROLOGY					
Functional neurological disorder	Connors et al. 2024	[76]	X		
Multiple sclerosis	Maresca et al. 2023	[77]	X		
Multiple sclerosis	Özdemir et al. 2025	[78]	X		
ADDICTIONS					
Smoking cessation	Abbot et al. 2000	[79]			X
Smoking cessation	Barnes et al. 2010	[80]			X
Smoking cessation	Barnes et al. 2019	[81]			X
Smoking cessation	Ekanayake and Elkins 2025	[82]	X		

Totals: 59 positive (72.0%); 6 not confirming effectiveness (7.3%); 17 inconclusive (20.7%). Total: 82 reviews.
CBT – cognitive behavioural therapy; IBS – irritable bowel syndrome; PTSD – post-traumatic stress disorder.

* Published online on 24 September 2025; assigned to the January 2026 issue.

Categories describe the review-level classification for the outcomes and populations considered. They do not represent pooled treatment effects, and reviews may contain overlapping primary studies. An inconclusive result is not evidence of absence of benefit.

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