BRITISH SOCIETY OF CLINICAL AND ACADEMIC HYPNOSIS

NEWSLETTER

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Branch Reports

Mets & South

We have already had two applications for the Foundation Training next year and we hope that this early interest will continue so that we get a decent number of trainees for 2019. Dr Maureen Tilford, who is the new BSCAH Communications Officer, as well as being a member of our branch, helped to organise a Mets and South workshop at the end of June. We are delighted that Dr Ann Williamson presented at this event, which is entitled 'Rapid Everyday Techniques for a Busy Practitioner'. Ann is a very experienced presenter and trainer. She is published author—she has written her own book, which offers practical solutions to psychological problems; she has co-edited our own handbook, and has written a number of peer-reviewed articles in the academic literature—and has kept herself up-to-date over the years with a huge range of techniques and strategies for clinical use..

Please continue to advertise these events and invite colleagues to attend training; it would be nice to have between 12 and 20 students for the Foundation Training and as many as possible for the workshops. Application forms are available on request: please contact me at dmjkraftesq@yahoo.co.uk. For information about the syllabus, please go to the BSCAH website or speak to me on 07946 579645. The courses are open to doctors, nurses, dentists, chartered psychologists and registered practitioners who have a legitimate reason for using hypnosis in their work.

David Kraft
Hon Secretary

Northern Counties Branch Report

'Tales of the unexpected' and 'Cutting the ties that bind' with Gill Smith and a 'mystery guest' is on 17 November at the Retreat York , and promises to be intriguing (postponed from March). Details are on the website.

Our 2019 Foundation Training is in Edinburgh on 26/27 January, 23/24 February, and 23/24 March .It is at Nicholson Square, where the recent neurological meeting was held. Members might consider coming as a refresher, modules may be available separately.

Gill continues to develop an active Edinburgh section of the Branch with Jane Boissiere and others, and there is an active peer support group.

We have a mini-taster meeting arranged on 6 December 2018 for the paediatric urology team at Great North Children's Hospital in Newcastle. We hope this may lead to an enthusiastic "cell" forming there.

We are hosting a BSCAH Oncology workshop for the wider membership as and when topics become coordinated nationally. This is to be on the 19th October 2019.We have an excellent relationship with the Queens Oncology and Haematology Centre at Castle Hill near Hull, the likely venue.

We normally have around three one day meetings per year, which have typically been at York, in March, summer , and November. Members of other Branches are welcome. The summer meeting is usually joint with Lancs and Cheshire Branch, but we didn't have one in 2018 partly relating to the cancelled March meeting due to weather, with loss of planning discussion, and partly to avoid clash with the national conference.

Grahame Smith
Branch Chair

https://www.aliem.com/2017/02/pem-pearls-calming-techniques-while-repairing-laceration/ has a little video talking about how to calm children - hypnosis by another name?

Lancs and Cheshire

At our AGM in April we took the decision to move to fewer, but longer meetings in an effort to increase numbers attending. As a result we have had only one meeting scheduled this Autumn. Sara Llewelyn came up from Midlands Branch and gave an excellent full day workshop on working with different modalities in therapy. Sadly only three members were able to attend, though one other did try to join us, but was defeated by the postgraduate centre having changed the means of accessing the building - something we only discovered on the day.

Sara discussed her methods and went through some interesting case histories. It is amazing the lengths Sara is willing to go in order to help patients, including converting her therapy room to an indoor beach to help a lady with a beach/sea phobia. The workshop was very interactive and we had plenty of opportunity for drawing and playing with trinkets, leading to some fascinating insights.

We have seven people taking part in this year's foundation training modules, including a doctor who is travelling from Australia to attend - keen indeed! We will hold a joint session with the trainees in January, followed by a one-day workshop on anxiety in March.

Linda Dunlop

Articles

Reflections on The ISH Congress

I have always found it disconcerting that some research results have been taken to mean that hypnotic inductions are redundant. An induction, some claim, is merely a little scene-setting ritual that has no impact upon subsequent results. Such thinking fits in very well with the old notion that hypnosis is little more than a social phenomenon, where a compliant subject says, in effect, "ah, you want me to have strange hypnosis-type experiences. I'll try to oblige." Even the rather sceptical socio-cognitive theorists acknowledged that people 'trying to oblige' endeavour to develop cognitive approaches that will bring about the desired effects. These approaches are actually strategies which, if successful, will result in their brain delivering the required conscious experiences. People who are highly susceptible to hypnosis seem to have the skill to make their very versatile brains produce any sensation or behaviour they wish. It would not be surprising if such people could spring into action at a moment's notice and behave 'hypnotically'. However, for more average people it seems reasonable to expect them to require something like a warm-up exercise if they are to perform at their best.

Who are those 'more average' people? At the recent Congress of the International Society of Hypnosis, in Montreal, a number of speakers drew attention to the problem of confining research to just hypnotic 'highs' and 'lows'. It has been a convenient way of maximising differences in behaviour, and hence potentially helping us to see what happens when people are hypnotised, but it misses out most of the population, and those, by definition, are representative of most patients seen by clinicians. Mark Jensen and his colleagues have been using electroencephalography (EEG) to characterise the electrical oscillations in the brains of people from across the whole hypnotic susceptibility spectrum. Different rates of oscillation are present simultaneously in our brains, just as an orchestra will produce low frequency notes from the double bases and tubas, together with a whole range of notes up to the high frequency violins and piccolos. Although a range of frequencies will be present, it is common for one register to predominate, such as the low, dark sonority of some of Wagner's pieces, or the soaring heights of Verdi. It is much the same in our heads, and Jensen's work has focussed on the 'deeper' end, the slow waves of the theta band: about 4 – 7 cycles per second. He finds that the more hypnotically susceptible people are, the 'louder' they tend to be in this range. That applies even before they are hypnotised, but during a hypnotic induction the amount of energy at these frequencies steadily increases. It is not a sudden switch into a different state.

Krisztian Kasos took a different approach. As with some old research of my own, he looks at asymmetries between the two hemispheres of the brain. This he does indirectly by measuring the skin conductance on the two sides of the body (the hands are often used). How easily a small electrical current can flow through the skin depends upon the level of sweat in the sweat glands (sweat is salty, so electrically conductive). The sweatiness, in turn, depends upon the level of arousal, which of course is determined by brain activity. Since the brain has two hemispheres, connected (contralaterally) to the two sides of the body, it is possible for those two sides to show

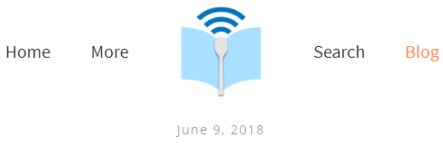
different current flows, reflecting levels of activity which differ slightly between the hemispheres. Krisztian tracked the changes during hypnotic induction, and showed (as others find) that in highs the right hemisphere becomes more active. Moreover, his result also showed that the process was not instantaneous, taking around nine minutes to develop. Therapists who believe in the merits of an induction seem to be vindicated.

Showing that the brain does different things in hypnosis was a useful nail in the coffin of the non-state theorists. It was another vindication for therapists, because many claimed that something really changed in hypnosis, and that it must be more than a bit of social compliance. Researchers, having established that the hypnotised brain can produce some startling effects, have moved on from seeking proof of these changes and are now trying to establish how the brain performs the feats. Two aspects of the 'trance' (Researchers still feel a bit awkward with that word!) have been examined. First is the feeling that things such as arm levitation feel as if they are happening 'by themselves'. Secondly, strange sensory experiences, such as 'seeing' someone who simply can't really be there, are accepted without challenge. A paper by Zoltan Dienes and Sam Hutton looks at the former. From previous research, they had reason to suppose that the region of brain which keeps us in touch with ourselves and, in effect, aware of our awareness, lies in the left dorso-lateral pre-frontal cortex. The researchers reasoned that, if one could interrupt the working of that left hemisphere region, then a moderately hypnotizable person would start to feel much more convincing effects, with responses to suggestions all seeming to happen by themselves. How does one interrupt the brain? One technique is called transcranial magnetic stimulation (TMS). A powerful, pulsating magnetic field is directed towards the appropriate part of the head, and this interferes with the workings of the cortex just below. The results of all this were just as had been proposed: the subjective experience of being hypnotised was enhanced when part of the left hemisphere was disabled. On the basis of that observation it is reasonable to suggest that when naturally highly hypnotisable people shift their brain's activity more towards the right, then it is achieving the same ends: they no longer use the self-monitoring left. However, there's a 'but' coming!

Max Coltheart and colleagues started from a different perspective, noting that brain damage in the right frontal region leads people to believe completely illogical illusions. An example is Capgras Delusion, where a patient thinks that someone close (e.g. a spouse) has been replaced by a replica. This would be analogous to 'trance logic' in hypnosis. Sure enough, mimicking brain damage by applying TMS to the right hemisphere enhanced hypnotic effects. So does that mean using TMS on either side of the brain makes people more hypnotically responsive? Well, not necessarily. Disconcertingly, when the group tried to replicate Zoltan's earlier findings, they could not get enhanced hypnotisability by disrupting the left hemisphere.

How should we resolve the apparent contradictions between the different research findings and explanations? Full resolution will only be achieved through more research, but something that is becoming very clear, and was mentioned frequently at the Congress, is that different people reach the same hypnotic goals by using different elements of the brain's vastly complex repertoire. This presents a challenge for researchers. Let me give an analogy. You have landed in a foreign country and cannot speak a word of the language, not even to order something to drink or a bite to eat. You get a wonderful idea! "I will sit in the bar and listen carefully to what people say, then see what they are served." However, just as you think you are getting the hang of it, you are confused by hearing what seem to be different words matched to servings. Your problem is that this is an international airport and different visitors are using their own languages; the clever barman is something of a polyglot, so he can respond to them all. Researchers are still very much in the position of the new arrival and have yet to acquire all the skills of the barman. And clinicians? Well, in some ways it is easier for them; they have an interpreter. The patient/client is in principle able to translate the therapist's words into the private language of their own brain. However, that channel cannot become fully effective unless the therapist speaks exactly the language of the patient-interpreter. That requires rapport, something which does not just happen. To speak that perfectly attuned language is not necessarily an easy task, although a skilled therapist may make it seem so.

Peter Naish



https://journalfeed.org/article-a-day/2018/when-learning-just-clicks talks about learning, and how to quiet the noise in our head. How best - positive reinforcement, and train us like dolphins. What do you think?

A potential future role for AI robots
- to improve mental health in loneliness and reinforce hypnotherapy gains?

It is now well recognised that loneliness is a significant factor contributing to depression and self neglect in older persons living alone, and may tip vulnerable persons who live "under the radar" towards suicide. Experience of using robots as artificial 'pets' in residential homes in Japan for stimulating interactions with these 'pets' has shown a positive effect with lifting of mood and improved socialising, as well as lifting mood and activity in elderly persons living alone: "Tomorrow's support-bots will help old folks stay mentally and socially engaged" . Such robots appear to be increasingly accepted in Japan as a socially acceptable way for isolated lonely persons to regain a sense of "sharing" one's life.

Trials in the UK and elsewhere have shown a positive result with humanoid robots used as limited care givers ("Scoping review on the use of socially assistive robot technology in elderly care"). As AI becomes more sophisticated and adaptable to human needs and demands, perhaps a role can be found in the future for such robot 'assistants' to speak or interact to consolidate and reinforce a patient's positive changes following completion of therapy sessions, perhaps by being a more interesting way than by asking the person to listen to tapes or read a text to consolidate results from the work done with the hypnotherapist.

"We're already finding that, for some difficult cases of depression, this could be a catalyst that helps people move on and get back to their healthy state," said Dr. Simon Davies, a staff psychiatrist and clinical scientist at Canada's Centre for Addiction and Mental Health. "It's very therapeutic -- another approach to use alongside all the regular treatments proving effective in depression treatment."

So, not a replacement for human therapists by a long shot, but perhaps a future complement to reinforcement of therapeutic results?

Greta Ross

Other Hypnosis Websites and Resources

BSCAH clearly has the best website you'll ever find - full of fantastic hypnosis resources and links! Http://www.bscah.co.uk

http://matthewwhalley.com/ This chap supervises MSc at UCL - his web sites are really good
Mat Whalley runs a number of public information websites:

Psychology Tools
Hypnosis And Suggestion
Hypnosis Training UK

HYPNOSIS AND SUGGESTION

HYPNOTC
thehypnotherapytrainingcompany

Although aimed at lay hypnotists, https://hypnotc.com/ has lots of useful hypnosis tips.

Evidence for the effectiveness of hypnosis in the management of pain

A while ago, NICE requested feedback and suggestions on their upcoming Pain management guidelines. BSCAH suggested that hypnosis could be added into the guideline, and contributed some evidence supporting that. We thought it might be useful to share our submission. If you have any further contributions or comments, please get in touch.

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Hypnosis has been defined as "a social interaction in which one person, designated the subject, responds to suggestions offered by another person, designated the hypnotist, for experiences involving alterations in perception, memory and voluntary action" Kilstrom (1985)[1].

Hypnosis has been used to treat every type of pain condition over centuries and across cultures (Pintar & Lynn, 2008[2]) and can be an extremely effective treatment for both acute and chronic pain. It is one of the most well researched areas in clinical hypnosis.

Hypnotic approaches for acute pain relief typically take three forms:

- Direct suggestion for symptom change
- Dissociative approaches – which encourage the patient to mentally 'go elsewhere' and leave the pain behind
- Resource utilisation - a more Ericksonian approach in which the patient uses their internal creativity and imagination

Management of chronic pain may include all the above but also often needs to address co-morbidities such as depression or psychosomatic symptomatology.

Hypnotic analgesia is dependent upon suggestion:

A key fact is that the induction of hypnosis by itself does not generate significant pain relief. It is the suggestion inside a hypnotic framework, or at least the expectation of pain relief which leads to reduction of pain. A number of studies have specifically assessed pain relief following a hypnotic induction, or the induction of hypnosis + specific suggestions (Knox et al, 1974[3]; Zachariae et al, 1998[4]). The induction of hypnosis alone is not generally sufficient to achieve significant pain relief.

Several controlled trials have demonstrated that hypnosis is an efficacious treatment for chronic pain. However, less attention has been given to the specific procedures and suggestions used in hypnotic treatments in research. The goal of this review (Dillworth & Jensen 2010) was to address the issue of differences in the content of hypnotic suggestions, including pain management suggestions, non-pain related suggestions, and post-hypnotic suggestions, in the context of published clinical trials of hypnosis for chronic pain management. This review focused on the types of suggestions used in twenty-five studies comparing hypnosis to active treatments (e.g., relaxation, biofeedback), non-treatment control groups (e.g., standard care/wait-list control, supportive attention), or both in adult populations with various chronic pain conditions. Overall, these studies found hypnosis to be more effective than non-treatment control groups and similarly effective when compared to active treatments on pain-related outcomes when either pain-related suggestions or non-pain related suggestions were used. However, for studies that included both pain-specific and non-pain related suggestions, hypnosis was found to be superior to active treatments on a variety of pain-related outcomes.

Hypnotic analgesia is not dependent upon endorphins

One early explanation for hypnotic analgesia was that it could be dependent upon the body's natural painkilling system - the endogenous opiate system. This was tested experimentally by Goldstein & Hilgard[5] in 1975. They administered the drug naloxone, which blocks the effects of opiates, to participants experiencing hypnotic analgesia. They found that hypnotic analgesia was not significantly affected by this inhibition of the opiate system, indicating that another mechanism must be responsible. Weitzenhoffer also pointed out that endogenous opiates are an unlikely source of hypnotic analgesia because of the latter's quick reversibility, and specificity (i.e. hypnotic analgesia can be directed at one location, leaving another unaffected).

Hypnotic analgesia is not dependent upon relaxation

Since many hypnotic inductions contain elements of relaxation it has been proposed that any pain relieving properties of hypnotic suggestion could be due primarily to a relaxation response. However, this hypothesis has been tested experimentally. Miller and colleagues (1991)[6] gave analgesia suggestions to two groups of participants: the first group were hypnotised using a traditional relaxation induction, the second group were hypnotised using an active-alert induction whist riding a stationary exercise bicycle. They found that the amount of pain relief experienced by

each group was equivalent, contradicting the idea that hypnotic analgesia is simply the result of relaxation.

Specific effects of hypnosis

Forty women suffering from temporomandibular disorders were randomized to four individual, one-hour sessions of either hypnotic intervention or a control condition of simple relaxation. The hypnosis group showed a significant reduction in their pain scores compared to the controls.

Forty-five patients with fibromyalgia were randomly assigned to: (a) hypnosis with relaxation suggestions; (b) hypnosis with analgesia suggestions; (c) relaxation. Findings indicate that analgesic suggestion can decrease pain intensity and the sensation of pain in patients with fibromyalgia. There was a greater decrease in pain intensity with the group that had analgesic suggestions than in the group with suggestions of relaxation.

Twenty-two patients with multiple sclerosis (MS) and chronic pain were recruited into a quasi-experimental trial comparing the effects of self-hypnosis training (HYP) with progressive muscle relaxation (PMR) on pain intensity and pain interference; 8 received HYP and the remaining 14 participants were randomly assigned to receive either HYP or PMR. HYP-condition participants reported significantly greater pre- to postsession as well as pre- to posttreatment decreases in pain and pain interference than PMR-condition participants, and gains were maintained at 3-month follow-up. Most of the participants in both conditions reported that they continued to use the skills they learned in treatment and experienced pain relief when they did so. General hypnotizability was not significantly related to treatment outcome, but treatment-outcome expectancy assessed before and after the first session was.

Hypnotic analgesia does not seem to be dependent upon imagery

Despite imagery often forming a key component when hypnosis is used clinically, one study has directly tested the additive benefits of imagery to hypnotic analgesia suggestions. Hargadon and colleagues (1995)[7] tested 66 high hypnotisables in three conditions: baseline, hypnotic analgesia with imagery encouraged, and hypnotic analgesia with imagery proscribed. Pain was rated as significantly less in the two hypnotic analgesia conditions compared to baseline, and there were no significant differences between the two treatment conditions. In contrast to this evidence, many clinicians report that the use of imagery in hypnosis is particularly useful in helping clients to engage with treatment. The experimental laboratory condition is, however, very different from the clinical situation and these findings were restricted to a highly hypnotisable population rather than a mixture of hypnotisability as is found in the clinical context.

What hypnosis can tell us about pain itself

As well as telling us more about hypnosis and suggestion a number of studies have had a feed-back effect and told us more about the nature of the pain system in humans.

Modulation of pain unpleasantness independent of sensory components

In 1997 Rainville and colleagues[8] published a landmark study which investigated the neural correlates of pain in humans. Using positron emission tomography (PET) they measured brain activity in a group of highly hypnotisable subjects while they had their hand immersed in either neutral (35ºc) or painfully hot (47ºc) water. Hypnotic suggestions were given for participants to experience increased and decreased pain unpleasantness and verbal pain reports were taken. The figure below shows the area of the anterior cingulate cortex found by Rainville to have activity which correlated with the reported unpleasantness of the pain. Interestingly, as early as 1962 this area of the brain had been thought to be involved in the perception of pain unpleasantness.

Using hypnosis to generate pain in the absence of a noxious stimulus

In a study investigating functional pain (pain without an obvious physical cause) Derbyshire and colleagues (2004)[9] published a study investigating brain activity in highly hypnotisable participants while they experienced physically-induced (PI), hypnotically-induced (HI), or imagined pain. Participants were pre-selected for their ability to hallucinate a sensation of pain. In both the PI and HI pain conditions participants were led to expect that an electrical heat probe attached to their hand would heat up to become painfully hot. However, painful heat was only delivered in the PI condition. In the HI condition, the probe was not switched on, but participants reported feeling

varying strengths of pain. In both the PI and HI conditions significant activations were reported in key areas of the pain network, including the thalamus, insula, anterior cingulate cortex, and prefrontal cortex. Additionally, activation was observed in the HI condition in the primary somatosensory cortex. Imagination of pain only resulted in minimal activation of the pain network. These results indicate that it is possible to experience pain in the absence of direct stimulation, and provide some evidence for direct cortical involvement in some clinical functional pain disorders. Similar results were reported in 2005 by Raij and colleagues[10].

If brain can create sensation of pain with hypnosis, then the brain should be able to create a sensation of relaxation and comfort with hypnosis. Unlike pharmacological treatments for pain, hypnosis has no negative side effects. Positive secondary benefits, such as improved well-being and sense of control, have been found in many studies.

Hypnotic approaches for chronic pain management: clinical implications of recent research findings. A useful article review article by Jensen reviews much of the current literature on the use of hypnosis in pain management. Many clinical trials have shown that hypnosis is effective for reducing chronic pain, although outcomes vary between individuals. The findings from these clinical trials also show that hypnotic treatments have a number of positive effects beyond pain control. Neurophysiological studies reveal that hypnotic analgesia has clear effects on brain and spinal-cord functioning that differ as a function of the specific hypnotic suggestions made, providing further evidence for the specific effects of hypnosis.
They write "findings from controlled trials indicate that hypnosis is effective for reducing chronic pain intensity on average, but that there is also substantial individual variation in outcome. Importantly, hypnosis for chronic pain has few negative side effects. In fact, with hypnotic treatment most patients report positive side effects, such as an improved sense of well-being, a greater sense of control, improved sleep, and increase satisfaction with life, independent of whether they report reductions in pain."

Meta-analyses
There have been a number of meta-analyses of hypnosis for pain control.
Kekecs et al looked at 26 studies and concluded that suggestive techniques might be useful tools to alleviate postoperative anxiety and pain; however, strength of the evidence is weak because of possible bias in the reviewed articles. For clinical purposes, they advised the use of hypnosis with live presentation to reduce postoperative anxiety and pain, until convincing evidence is uncovered for the effectiveness of therapeutic suggestions and recorded presentation. Pain management with adjunct suggestive interventions is mostly encouraged in minor rather than major surgeries.

Adachi et al conducted a meta-analysis in 2014 to assess the efficacy of hypnosis for managing chronic pain. When compared with standard care, hypnosis provided moderate treatment benefit. Hypnosis also showed a moderate superior effect as compared to other psychological interventions for a non-headache group. The results suggest that hypnosis is efficacious for managing chronic pain.

Montgomery et al conducted a meta-analysis that examined the results of 20 published controlled studies examining the use of hypnosis as an adjunct with surgical patients. In these studies, hypnosis was typically administered to patients in the form of a relaxing induction phase followed by suggestions for the control of side effect profiles (e.g. pain, nausea, distress). Only studies in which patients were randomised to either a hypnosis or control group (no-treatment, routine care, or attention control group) were included. The results revealed that patients in the hypnosis treatment groups had better outcomes than 89% of the patients in the control groups. It was found that adjunctive hypnosis helped the majority of patients reduce adverse consequences of surgical interventions.

Montgomery et al conducted a meta-analysis examining the effectiveness of hypnosis in pain management. It compared studies that evaluated hypnotic pain reduction in healthy volunteers vs. those using patient samples, looks at the relationship between hypno-analgesic effects and participants' hypnotic suggestibility, and determines the effectiveness of hypnotic suggestion for pain relief relative to other nonhypnotic psychological interventions. Examination of 18 studies

revealed a moderate to large hypno-analgesic effect, supporting the efficacy of hypnotic techniques for pain management. The results also indicated that hypnotic suggestion was equally effective in reducing both clinical and experimental pain.

Jensen summarizes the previous reviews of randomized, controlled trials of hypnotic analgesia for the treatment of chronic and acute pain in adults, and reviews similar trials which have recently been published in the scientific literature. The results indicate that for both chronic and acute pain conditions: (1) hypnotic analgesia consistently results in greater decreases in a variety of pain outcomes compared to no treatment/standard care; (2) hypnosis frequently out-performs non-hypnotic interventions (e.g. education, supportive therapy) in terms of reductions in pain-related outcomes; and (3) hypnosis performs similarly to treatments that contain hypnotic elements (such as progressive muscle relaxation), but is not surpassed in efficacy by these alternative treatments

Elkins reviews thirteen controlled prospective trials of hypnosis for the treatment of chronic pain, excluding studies of headaches, that compared outcomes from hypnosis to either baseline data or a control condition. The findings indicate that hypnosis interventions consistently produce significant decreases in pain associated with a variety of chronic-pain problems. Also, hypnosis was generally found to be more effective than nonhypnotic interventions such as attention, physical therapy, and education. Most of the hypnosis interventions for chronic pain include instructions in self-hypnosis.

Lebon's study aim was to evaluate the effectiveness of physical therapy under hypnotherapy to treat this condition. Twenty patients with CRPS-1 at the wrist and hand were evaluated retrospectively: 13 women and 7 men with an average age of 56 years (34–75). Thirteen patients were in the inflammatory phase and 7 in the dystrophic phase. The main endpoints were pain (VAS, analgesic use), stiffness (wrist and finger range of motion), and strength (pinch and grasp). Secondary endpoints were functional scores (QuickDASH, PWRE), patient satisfaction, return to work, and side effects. Results were satisfactory in all cases after 5.4 sessions on average. VAS decreased by 4 points, PWRE-pain by 4.1 points, and analgesic use was limited to paracetamol upon request. Finger and wrist range of motion increased and the QuickDASH decreased by 34 points, PRWE-function by 3.8 points, pinch strength increased 4 points, and grasp strength by 10 points. Return to work was possible in 80% of the cases. All patients were satisfied or very satisfied with the treatment. Physical therapy under hypnosis appears to be an effective treatment for CRPS-1 at the wrist and hand no matter the aetiology.

Fidanza compared the effects of explicit suggestions of analgesia and of the activation of the Diffuse Noxious Inhibitory Control (DNIC) by cold pressor test on pain perception and heart rate in healthy participants with high (highs, N = 18), low (lows, N = 18) and intermediate scores of hypnotizability (mediums, N = 15) out of hypnosis. Pain reports and the stimulus-locked heart rate changes induced by electrical nociceptive stimulation of the left hand were studied in the absence of concomitant stimuli (Control), during suggestions of analgesia (SUGG, glove analgesia) and during cold pressor test used as a conditioning stimulus to the right hand (DNIC, water temperature = 10–12 °C) in the REAL session. Participants were submitted also to a SHAM session in which the DNIC water temperature was 30 °C and the suggestions for analgesia were substituted with weather forecast information. Both suggestions and DNIC reduced pain significantly in all subjects; however, the percentage of reduction was significantly larger in highs (pain intensity = 55% of the control condition) than in mediums (70%) and lows (80%) independently of the REAL/SHAM session and of the specific pain manipulation. Heart rate was not modulated consistently with pain experience. Findings indicate that both suggestions and DNIC influence pain experience as a function of hypnotizability and suggest that both sensory and cognitive mechanisms co-operate in DNIC induced analgesia

Tan et al randomised 100 veterans with chronic low back pain into 4 treatment groups: 1) 8 session of hypnosis, 2) 8 sessions of hypnosis + recordings, 3) 2 sessions of hypnosis + recordings, 4) 8 sessions of biofeedback. Participants in all conditions reported significant reductions in pain, but improvements were greater in the hypnosis groups, and treatment gains were maintained over 3 months. There were no differences between the hypnosis groups, indicating that even very short hypnosis interventions can be effective in relieving pain.

Teeley administered virtual reality hypnosis treatment was administered on 2 consecutive days, and pain and anxiety were assessed each day before and after VRH treatment as well as on Day 3, which was 24 hours after the second treatment session. Pain reduction from baseline to Day 3 was from 70% to 30%, despite opioid analgesic use remaining stable. The subjective pain reduction reported by patients was encouraging, and the results of this case series suggest the importance of further study of VRH with larger samples using randomized controlled trials

Jensen's trial involved eight women who were in treatment for breast cancer (n = 4) or breast cancer survivors (n = 4), presenting with 1 or more of 4 symptoms (chronic pain, fatigue, hot flashes, and sleep difficulties), were given 4 to 5 sessions of self-hypnosis training for symptom management. Analyses revealed (a) significant pre- to posttreatment decreases in pain intensity, fatigue, and sleep problems and (b) that pain intensity continued to decrease from post treatment to 6-month follow-up.

Jensen looked again further at fifteen adults with multiple sclerosis were given 16 sessions of treatment for chronic pain that included 4 sessions each of 4 different treatment modules: (a) an education control intervention; (b) self-hypnosis training (HYP); (c) cognitive restructuring (CR); and (d) a combined hypnosis-cognitive restructuring intervention (CR-HYP). The findings supported the greater beneficial effects of HYP, relative to CR, on average pain intensity. The CR-HYP treatment appeared to have beneficial effects greater than the effects of CR and HYP alone. Future research examining the efficacy of an intervention that combines CR and HYP is warranted.

Patterson reported a randomized, controlled study of 21 hospitalized trauma patients to assess the analgesic efficacy of virtual reality hypnosis (VRH)-hypnotic induction and analgesic suggestion delivered by customized virtual reality (VR) hardware/software. Subjective pain ratings were obtained immediately and 8 hours after VRH (used as an adjunct to standard analgesic care) and compared to both adjunctive VR without hypnosis and standard care alone. VRH patients reported less pain intensity and less pain unpleasantness compared to control groups.

Barber looked at thirty-seven adults with spinal-cord injury and chronic pain were randomly assigned to receive 10 sessions of self-hypnosis (HYP) or EMG biofeedback relaxation (BIO) training for pain management. Participants in both treatment conditions reported substantial, but similar, decreases in pain intensity from before to after the treatment sessions. However, participants in the HYP condition, but not the BIO condition, reported statistically significant decreases in daily average pain pre- to posttreatment. These pre- to posttreatment decreases in pain reported by the HYP participants were maintained at 3-month follow-up.

Abrahamsen looked at forty-one patients with persistent idiopathic orofacial pain who were randomized to active hypnotic intervention or simple relaxation as control,
for five individual 1-h sessions. Hypnosis seems to offer clinically relevant pain relief in PIOP, particularly in highly susceptible patients. However, stress coping skills and unresolved psychological problems need to be included in a comprehensive management plan in order also to address psychological symptoms and quality of life.

Stoelb looked at the mounting evidence base for the use of hypnosis in the peri and intra-surgical situation.

In 2002 Lang and Rosen conducted a prospective randomized study in which patients undergoing vascular and renal interventional procedures underwent either standard sedation (n = 79) or sedation with adjunct hypnosis (n = 82). According to data from this experience, the cost associated with standard sedation during a procedure was $638, compared with $300 for sedation with adjunct hypnosis, which resulted in a savings of $338 per case with hypnosis. Although hypnosis was known to reduce room time, hypnosis remained more cost-effective even if it added an additional 58.2 minutes to the room time.
This demonstrated the cost effectiveness of a simple hypnotic intervention. Professor Lang's studies demonstrate the effectiveness of a scripted intervention, other studies show an even greater effect with more tailored interventions.

Droueta looked at various hypnotic techniques used in anaesthesia, either on their own or as adjuncts. A new hypnotic technique, hypnopraxia, was tested in 5 patients undergoing various procedures (4 colonoscopies, 1 inguinal hernia repair, and 1 transobturator tape procedure). The patients were accompanied throughout the procedure by an anaesthetist trained in hypnoanaesthesia and hypnopraxia. Initially developed for use in hypnotherapy, the accompaniment with hypnopraxia relied on the closeness of the link between the anaesthetist and the patient. This was constantly built in the present moment, here and now, by giving back to the patient what the anaesthetist observed of the manifestations of the patient's unconscious mind (the patient's speech and choice of words, facial micro-expressions, involuntary bodily movements, and emotions). The anaesthetist's verbal accompaniment was therefore determined by the patient. No other anaesthetic technique was needed during the colonoscopies. For the 2 surgical procedures, some Sufentanil was given and local anaesthetic was applied by the surgeon. All 5 patients were well satisfied after the procedure. They were especially pleased at having been able to go through their procedure without needing any drug anesthesia, and at being in charge throughout.

Another study by Lang looked at 241 patients were randomised to receive intraoperatively standard care (n=79), structured attention (n=80), or self-hypnotic relaxation (n=82). Structured attention and self-hypnotic relaxation proved beneficial during invasive medical procedures. Hypnosis had more pronounced effects on pain and anxiety reduction, and is superior, in that it also improved haemodynamic stability. Procedure times were significantly shorter in the hypnosis group (61 min) than in the standard group (78 min, p=0.0016) with procedure duration of the attention group in between (67 min).

Defechereux investigated twenty patients operated under hypnoanesthesia were compared to 20 patients operated under conventional anesthesia Significant differences in terms of inflammatory response and hemodynamic parameters were observed in favor of hypnoanesthesia. Patients of the hypnoanesthesia group had significantly less postoperative pain. Postoperative fatigue syndrome and convalescence were also significantly improved in these patients.

Faymonville reviews the clinical experience of using hypnosis with conscious sedation and local anaesthesia (ie hypnosedation) successfully with 1650 patients.

Defechereux documents between April 1994 and June 1997, 197 thyroidectomies and 21 cervical explorations for hyperparathyroidism were performed under hypnoanesthesia (HYP). Operative data and postoperative course were compared to a clinically similar, contemporary population of patients (n = 119) who were operated on under general anesthesia (GA). All patients having HYP reported a pleasant experience and had significantly less postoperative pain and analgesic use. Hospital stay was also significantly shorter, providing a substantial reduction in the costs of medical care. The postoperative convalescence was significantly improved after HYP and a full return to social or professional activity was significantly quicker.
21 patients underwent a cervicotomy under hypnosedation for primary hyperparathyroidism (HPT). No conversion to general anaesthesia was needed.

Faymonvile looks at how since 1992, hypnosis has been used routinely in more than 1400 patients undergoing surgery. Hypnosis used as an adjunct to conscious sedation and local anesthesia was associated with improved intraoperative patient comfort, and with reduced anxiety, pain, intraoperative requirements for anxiolytic and analgesic drugs, optimal surgical conditions and faster recovery of the patient.

Faymonville provided some more research - sixty patients scheduled for elective plastic surgery under local anesthesia and intravenous sedation (midazolam and alfentanil upon request) were included in the study. They were randomly allocated to either stress reducing strategies (CONT) or hypnosis (HYP) during the entire surgical procedure. Peri- and postoperative anxiety and pain were significantly lower in the HYP group as well as a significant reduction in intraoperative requirements for midazolam and alfentanil. Vital signs were significantly more stable in the HYP group and patient satisfaction scores was significantly higher.

Faymonville completed another retrospective study included 337 patients undergoing minor and

major plastic surgical procedures under local anesthesia and conscious intravenous sedation. Patients were divided into three groups depending on the sedation technique: intravenous sedation (n = 137); hypnosis (n = 172), during which patients achieved a hypnotic trance level with age regression; and relaxation (n = 28). Intraoperative anxiety reported by patients in the hypnosis group (0.7 +/- 0.11) and in the relaxation group (2.08 +/- 0.4) was significantly (P < .001) less than in the intravenous sedation group (5.6 +/- 1.6). Pain scores during surgery were significantly greater in the intravenous sedation group (4.9 +/- 0.6) than in the hypnosis group (1.36 +/- 0.12; P < .001) and the relaxation group (1.82 +/- 0.6; P < .01). Furthermore, midazolam requirements were significantly lower in the hypnosis group (P < .001) and in the relaxation group (P < .01) as compared with the intravenous sedation group. Postoperative nausea and vomiting were reported by 1.2% of patients in the hypnosis group, 12.8% in the relaxation group and 26.7% in the intravenous sedation group. Greater patient satisfaction with the anaesthetic procedure and greater surgical comfort were also reported in the hypnosis group.

Patterson and Jensen discuss how studies on the mechanisms of laboratory pain reduction show central nervous system activity during hypnotic procedures that offer possible physiological mechanisms of hypnotic analgesia. Randomized controlled studies with clinical populations indicate that hypnosis has a reliable and significant impact on acute procedural pain and chronic pain conditions.

Using a parametric single-trial thulium-YAG laser fMRI paradigm, Vanhaudenhuyse et al assessed changes in brain activation and connectivity related to the hypnotic state as compared to normal wakefulness in 13 healthy volunteers.

This study by Macquet compared the differences in cerebral blood flow in subjects who were asked to relive a pleasant autobiographical experience whilst in hypnosis or in the normal 'wakeful' state.

This study by Wik examined regional cerebral blood flow with positron emission tomography in patients with fibromyalgia, during hypnotically-induced analgesia and resting wakefulness. The patients experienced less pain during hypnosis than at rest. The observed blood-flow pattern supports notions of a multifactorial nature of hypnotic analgesia, with an interplay between cortical and subcortical brain dynamics.

Two further Faymonville studies comment: As well as assessing changes in cerebral functional connectivity related to the hypnotic state (compared with simple distraction and the resting state) hypnosis was shown to reduce pain perception by 50%. Pain perception during rest and mental imagery was not significantly different.

Key points from the well-controlled trials of the past 20 years, relative to standard care:

1. Hypnosis is more effective for reducing daily chronic pain, benefits remain up to a year.

26 participants in a case series of hypnotic analgesia for chronic pain were examined to determine the long-term effects of hypnosis treatment. Statistically significant decreases in average daily pain intensity, relative to pre-treatment values, were observed at posttreatment and at 3- and 9-month follow-up. The percent of participants who reported clinically meaningful decreases in pain were 27%, 19%, 19%, and 23%, at the 3-, 6-, 9-, and 12-month follow-up points, respectively. Moreover, at 12-months posttreatment, 81% of the sample reported that they still used the self-hypnosis skills learned in treatment

2. Hypnosis has been found to be either as or more effective than other pain treatments.

The authors asked breast cancer patients to participate in 1 of 3 mind-body interventions (cognitive-behavioural therapy (CBT), yoga, or self-hypnosis) to explore their feasibility, ease of compliance, and impact on the participants' distress, quality of life (QoL), sleep, and mental adjustment. Ninety-nine patients completed an intervention (CBT: n = 10; yoga: n = 21; and self-hypnosis: n = 68). Results showed high feasibility and high compliance. After the interventions, there was no significant effect in the CBT group but significant positive effects on distress in the yoga and self-hypnosis groups, and, also, on QoL, sleep, and mental adjustment in the self-hypnosis group.

Participants reporting pain from hip or knee osteoarthritis were randomly assigned to one of the

following conditions: (a) hypnosis (i.e. standardized eight-session hypnosis treatment); (b) relaxation (i.e. standardized eight sessions of Jacobson's relaxation treatment); (c) control (i.e. waiting list). Overall, results show that the two experimental groups had a lower level of subjective pain than the control group and that the level of subjective pain decreased with time. The beneficial effects of treatment appeared more rapidly for the hypnosis group. Results also show that hypnosis and relaxation are effective in reducing the amount of analgesic medication taken by participants.

40 female patients with myofascial pain were allocated to 1 of 3 possible treatment groups: (1) hypnorelaxation (n = 15), (2) occlusal appliance (n = 15), and (3) minimal treatment group (n = 10). Hypnorelaxation and occlusal appliance were more effective than minimal treatment regarding alleviating muscular sensitivity to palpation. However, only hypnorelaxation (but not occlusal appliance) was significantly more effective than minimal treatment with regard to the patient's subjective report of pain.
THIS ARTICLE INCLUDING DETAILS OF ALL REFERENCES CAN BE FOUND AT
https://www.bscah.com/about-hypnosis/information-health-professionals

In Conclusion

- Majority report significant & meaningful reductions in pain intensity
- Many will continue to use self-hypnosis or audio recordings outside clinic settings
- Many achieve lasting reductions in pain
- May be useful for helping decrease the frequency of unhelpful pain related thoughts, anxiety, and improve sleep.

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Improving sleep sounds great. Why not have a look at this hypnosis for sleep track from Eamonn Covney - free and easily accessible.
https://soundcloud.com/user-486534099

Emergency Medicine Hypnosis

I'm a Consultant in Emergency Medicine in Nottingham. I have been practicing clinical hypnosis for the last 20 years. My parents are both GPs and they taught me how to use hypnosis initially to reduce exam stress. I have been using hypnosis since then as an adjuvant for acute and procedural pain. In addition, I have used it to reduce anxiety in a number of other emergency settings, such as asthma and COPD.

More recently I have completed an Advanced Diploma in Clinical Hypnosis and related techniques from Birmingham City University. On this course I learned the importance of language as well as some CBT techniques.

I wanted to introduce hypnosis to my staff so that they could eventually help patients with their aim. Due to the healthy scepticism that exists around the hypnosis, I thought the best way to introduce hypnosis widely was for staff to experience it themselves on some level first.

I lead on a new Wellbeing operational group within my Emergency Department. We have been running sessions on our team training days. The idea behind this was to help staff get through what promises to be another difficult winter and introduce them to hypnosis as a strategy.

The sessions focus on stress, the underlying physiology and problems caused by chronic stress. Followed by interventions to help to recognise this in ourselves and others. Then on strategies to reduce this. The main intervention being to explain basic CBT and to tell staff about how they can change their feelings by 'talking back' to negative automatic thoughts and by reframing problem thinking. This is then reinforced by a hypnosis audio done by my colleague Jules Carr a Specialist Dermatology nurse, who I met while doing the Diploma. I also teach staff breathing and visualisation techniques for personal use while on the 'shopfloor'.

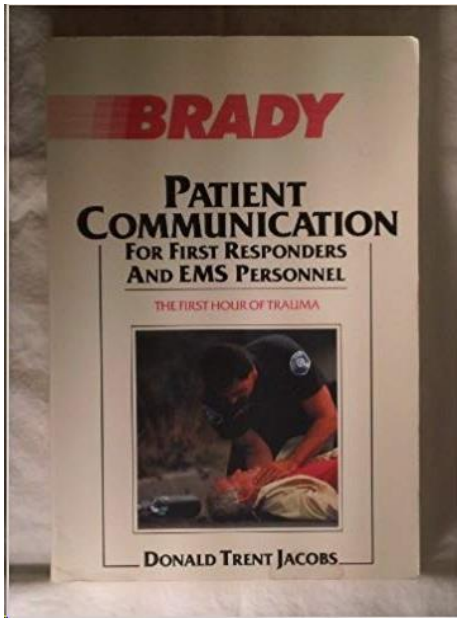
The written and verbal feedback from these sessions has been much better than we expected. With some staff saying their lives have been changed.

I was also lucky enough to be invited to run a workshop on hypnosis for acute and procedural at the Royal College of Anaesthetists in conjunction with the British Pain Society and BSCAH. Again the feedback from this day was very good, with several participants saying they would do formal BSCAH courses in the future.

Charlotte and I are currently exploring the possibility of doing an RCEM (Royal College of Emergency Medicine) study day - contact us for more details, or to help.

I would be very interested to hear from any members who introduced hypnosis to their own work places.

Honeyia Minhas



Patient Communication for First Responders and EMS Personnel: The First Hour of Trauma is a book that can be difficult to find. If you can track a copy down, I think I'd thoroughly recommend it. It's slim, but jam packed full of structure for dealing with patients who have suffered trauma. It's something we should all think about reading, and is well written, and well structured.

Currently available second hand on amazon for 1p.

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The 25th World Congress of Psychosomatic Medicine 2019 is looking for abstract submissions. Why not get writing?

ICPM

A Bedside Manner: The Art of Elegant Consulting

This book is a summary of what I have learned about practising and teaching the art of the Consultation most effectively in my 35 years as a GP. For 25 of these years I was a GP Trainer, and the principles I have identified that worked for me have advised much of what I sought to pass on to my registrars about the process of consulting. There are many excellent sources of guidance about the content of the consultation: the "what to do", but not so much about "how" to do it. In this book I have described the approach to consulting that has worked well for me, in the hope that my readers may find something of value for them. This book is empirical and anecdotal: what worked, and continues to work for me.

I found General Practice enjoyable and satisfying for the greatest part. I have attempted to illustrate why in this book. I hope that doctors in the early days of their exploration of the field will be curious to try some of the techniques I describe, and that more experienced readers may also find new ways of looking at their approach.

The book was written from my perspective as a GP, but I feel the principles are applicable to any conversation where the intention is to help and support someone as they find their own way through their challenges. I have an interest in Complementary Medicine. My studies and training in the fields of Clinical Hypnosis, NLP, Mindfulness, Coaching and Generative Change work have particularly influenced my day-to-day clinical practice, and are reflected in the book. My interest in this aspect of the consultation was sparked in 1993 when I read Dr.Roger Neighbour's "The Inner Consultation" when I was training as a GP Trainer. I was already interested in Dr.Milton Erickson's work and these threads both led me to study NLP and train in Medical Hypnosis. Very few, if any, of the ideas in the

book are my own. I have learned from seeking out and studying with the best teachers I could find in the various fields that interest me.

For clarity I have identified and isolated eight aspects of the consultation for individual discussion. When put together they constitute a comprehensive approach to consulting well. In practice, of course, these elements are often running simultaneously.

The first three building blocks, which I consider essential to all consultations, are the states of clinician, the patient and the rapport they build as a result, both internally within them-selves, and in their interaction with each other.

The most important single factor in achieving an outcome is our state. Means of accessing and maintaining optimum states, both in ourselves and our patients, are discussed. This book starts by looking closely at the factors that influence this, and offers some advice on how to start to develop a regular, daily habit of building and reinforcing the best states in ourselves. This leads into an exploration of methods of building and maintaining rapport, and the importance of accurate and regular calibration of this so that it is maintained and re-established quickly when lost. I highlight the need for being aware of, and responsive to, the non-verbal aspects of the conversation, thus enabling the clinician to pace and support their patient as they find their way.

I then look at ways of appropriately identifying hope with patients. This is especially relevant in General Practice. Patients often find themselves back in the hands of their GP when all the conventional and evidence-based options for their situation have been exhausted. Here working with the patient's attitude is so important, helping them to mobilise their own internal strengths and resources.

Then follows an exploration of the importance of goal- setting. For this I introduce a model that I find more flexible than the traditional SMART model, which was initially designed as a business management tool rather than for interpersonal interaction. The importance of identifying and attaching feeling and emotion to whatever goals emerge is highlighted and leads to a discussions on building and maintaining motivation.

All the above is then incorporated into a fluent interchange with the patient that will be applicable to any length of consultation, although I have based the book on the standard GP ten-minute appointment.

The book concludes with discussion on reflection and learning from each consultation, some tips on what to do if things are not running smoothly, and a brief summary chapter.

I have deliberately kept the book as short as I could, without leaving out anything of significance. I have provided some examples to illustrate points, but intend it essentially a primer: something to raise awareness of the process of the consultation, to stimulate curiosity and to encourage the reader to go out and explore their consulting through some different lenses. My aim is for it to be useful rather than factual, and hopefully a resource that people come back to from time to time for an idea or a hint to nudge themselves along.

Mark Chambers

The Truth About Hypnosis and Its Effects: an Interview with Marco Mozzoni

The psychologist Marco Mozzoni wrote the book "Ipnosi in pillole"
"Unfortunately, it is still common to believe that hypnosis is a form of manipulation [...]". "Indeed, the opposite happens: thanks to the hypnosis practiced by medical doctors and psychologists, people are often able to regain full control of themselves",

I must say, it is admirable how clear and concise Marco Mozzoni is in his new book "Ipnosi in pillole" (Armando Editore, Rome 2018). He chose a very complex subject and put it into a volume that is really easy to read. The exercise of these qualities is all the more appreciable the more the topic is the object of the strangest beliefs and the victim of cyclical prejudices. The book's scientific rigor is a

welcome element for those who have long been asking the "experts" for a precise and updated picture of a phenomenon that so far has seldom been properly addressed. Of course, his activity as a journalist and scientific communicator along with his activity as a neuropsychologist and psychotherapist specialized in clinical hypnosis, as well as his teaching activity in both disciplines, help him to provide the reader with a rigorous, informed, detailed yet simple presentation of the topic.

Even today there are false beliefs about what hypnosis is, what it is used for and what the hypnotic state consists of. According to your experience, which false beliefs are most widespread?
"Unfortunately, it is still common to believe that hypnosis is a form of manipulation, a mentalist technique that induces people to lose consciousness while someone else takes control of and manipulates it at his will. Nonsense. Indeed, the opposite happens: thanks to the hypnosis practiced by medical doctors and psychologists, people are often able to regain full control of themselves and become the main agent in their own cure and daily improvement. People are thus freed from problems that have thwarted them for years, finally regaining control over their lives. This comes to the annoyance of those whose professions are based on the chronicity of ills. Recently, we conducted a survey, the first of its kind in Italy, precisely on people's knowledge about hypnosis. Results showed that Italians do not know about the uses of hypnosis in the medical field (over 80% of participants), in pain therapy (70%), in prevention (80%), nor in the treatment of specific diseases (84%). Moreover, more than half of the participants seem to be completely unaware of what self-hypnosis is. My book "Ipnosi in pillole" may help fill these gaps and give readers a useful heads up about this extremely effective and promising technique".

Where do these misconceptions come from? How can we eradicate them?
"It is not hard to see where these misconceptions come from. Just look at what has been presented as hypnosis for the last thirty years in television broadcasts. And the excellent volumes written by authoritative experts, even those in Italy, are lost on bookshelves, buried under a plethora of publications by self-styled "hypnologists" who often lack the minimum requirements to practice any profession. Against this misinformation, I believe that battles in court are of little use. It is much more useful to promote a rigorous scientific information, accessible to everyone, using communication methods capable of involving people in initiatives and hypnotic practice. Books, articles, radio interviews and TV services are fine, but let's not stop there. For example, we, at the Clinical Hypnosis Center in Rome have been engaged for years in organizing free meetings and open seminars, where we illustrate the neuroscientific bases of hypnosis, the evidence of its effectiveness and how lifestyles that are problematic can be changed. We provide solid, tactical experiential learning so that people can truly know what the hypnotic state is and what it can do for them. In a way, the book is the result of these initiatives, which have met with success way beyond expectations".

What, then, is clinical hypnosis?
"In the context of the so-called "mind-body medicine", clinical hypnosis is the most effective natural modality of human capacity expansion to facilitate the restoration and self-regulation of the neuro-psycho-physiological functions of the organism. Compared to other methods, it works preferentially with the unconscious, as an enzyme to accelerate internal processes of self-healing and improvement. It works well because it exploits and empowers, in the first instance, the natural processes of self-repair of the body. Indeed, our wounds often heal by themselves. Our brain is plastic, that is, it continuously modifies itself based on the experiences we have, even the unconscious ones, reinforcing the most used brain networks, which become more and more efficient. Together with brain plasticity, neurogenesis is another important, universally recognized element. New nerve cells can also be born in adulthood, forming a strategic reserve that hypnosis knows how to tap into. Finally, the human being is a deeply psychosomatic entity. No need to explain this. It is something we feel every day simply by living. And hypnosis is the most successful way to work on the psychosomatic".

What are its main applications?
"In its reparative function hypnosis serves the function of helping, sometimes fundamentally, in the treatment process of medical and psychological problems such as anxiety, panic attacks (more and more frequent among young people), depression, phobias, immune system disorders, chronic pain

and other disorders that are nowadays widespread, such as substance addictions, weight problems and obesity. In its generative function it can enhance human performance at all ages in sport, work, study, and even personal relationships. Creativity, decision-making processes, attention, are all faculties that can benefit from hypnosis. At a regulatory level, it can help people to stay healthy. This is because it enables them, at a certain point, to self-regulate physiological functions such as emotions, hormones, nervous system activity, sleep-wake cycles, especially if self-hypnosis is learned immediately and used as a daily practice that reinforces the effect of therapy. It really takes just five minutes a day to keep the psychotherapist away".

What happens to the brain during hypnosis? How does the subject enter in a different state than the ordinary one?
"In hypnosis, we witness a shift of the encephalic activity prevalent from the frontal regions of the left hemisphere to the posterior regions of the right hemisphere, detectable with functional magnetic resonance and other devices. In essence, the inhibition of the various areas of the brain by the frontal cortices characteristic of the ordinary state is temporarily reduced. It is as if we were initially playing in a classical orchestra, with a conductor, and a jazz ensemble suddenly started, one in which the melody is created gradually, with the individual contribution of each element blended in, in an expressive bottom-up process, enabling us to explore unimaginable creative alternatives, in the ordinary state filtered by rigid patterns of consciousness. We can also record with electroencephalography the passage from a prevalence of beta waves to alpha waves, typical of relaxation, and theta, typical of REM sleep and of dream activity. Finally, the internal clock slows down and time seems to flow faster, as happens in love and pleasant experiences, which run out in a moment. The temporal distortion is in fact one of the most reliable indicators of the "trance", as Americans put it. In general, the physiological rhythms, from breathing to the pulsations of the heart beating and the release of hormones, are regularized, with a recovery of energy that almost seems to say "recharge the batteries when needed". It is also important to know that in a state of hypnosis the body releases endogenous opioids, endorphins, enkephalins, anandamide and other molecules with pain-relieving, anxiolytic and antidepressant powers, which are our natural "drugs"".

Reading your book, I noticed some degree of polemic towards the other approaches that exist today to address psychological problems…
"The criticisms come from years of clinical experience that has led me to the conclusion that hypnosis is still seen as the last resort. People get tired of inconclusive peregrinations, often lasting years. They lose a piece of their lives, hoping to get better. Then, they may say "I've tried everything, I have nothing left but hypnosis". How many times have I heard this sentence! People that, after countless failed attempts to solve their problems with the help of an overly long series of "specialists" or fashionable therapies, before finally giving up and throwing in the towel, feel they should give it one last chance. And, "miraculously", with hypnosis they finally find an answer, without a lot of reasoning, without the need to re-examine the past in search of the usual faults to be attributed to someone or something else: simply by becoming familiar with a regenerative functioning mode which today is just too out of the ordinary. Too bad, I think, because they could have started from hypnosis, and saved lots of time and money. There is no polemic here, it is just a fact. Hypnosis works where other therapies have not or have made the situation worse. And maybe the reason why it works so well is precisely because we know that hypnosis does not only deal with the mental aspect, but with the body as a whole, including the mind. After all, this is just what we are. We are not a sum of a lot of different pieces. We are one whole. Disciplinary fragmentation is useful for scientific enterprises but not in solving life problems. Personally, I think that the problem of finding the connection between the mind and the body, that has perplexed us for centuries without reaching a consensus, is a false problem, an illusory game, a doubling (perhaps only due to inventing two different terms to represent the same thing from two different points of view) of something absolutely "one". Although we are complex entities immersed in a world in relation with other beings, although we are composed of innumerable systems, billions of neurons, cells, infinite thoughts and dispositions of mind, we are still "concentrated in one point", as Hegel said of Napoleon in Jena".

How is hypnosis considered today in the clinical context?
"In other countries, such as France, Germany, Belgium and the United States, hypnosis is now a widespread practice in hospitals, but not only. It has the advantage of not having side effects,

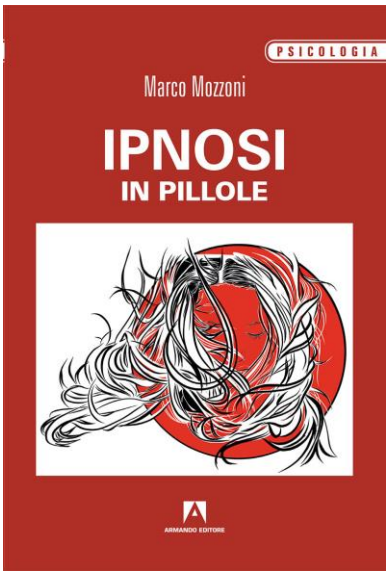
reducing drug use and hospitalization time, improving the quality of patients' lives and allowing significant savings to the coffers of national health services. At the World Economic Forum this year in Davos, psychiatrist David Spiegel, professor at Stanford University, talked about how hypnosis could reduce the abuse of opioid pain medications, that has become a social scourge everywhere. In a recent study, the American professor showed that cancer patients treated with hypnosis and self-hypnosis perceived half the pain and lived longer than those treated conventionally. Also, in the USA, Guy Montgomery, working at the Icahn School of Medicine at Mount Sinai in New York, thanks to a grant obtained from the National Institutes of Health (NIH), is training the health staff of numerous medical centres across the country, as he believes that hypnosis represents a polyvalent method, much like a Swiss army knife, useful in every context. In France, thanks to hypnosis, giving general anesthesia to patients can be avoided, and the mastectomy has become an outpatient practice in the main institutions: enter at 9 am and go out at 1 pm on your legs, lucid and ready for recovery. There is a growing body of research that supports hypnotic interventions in health care, both in the medical context and in psychotherapy. Today we have considerable scientific evidence on the effectiveness of the so-called "mind-body" interventions, in which hypnosis has a rather marginal place, that can be of great benefit in the treatment of various disorders, from chronic pain to anxiety, from stress for medical procedures to symptoms of menopause, from sleep disorders to intestinal disorders, just to give some examples. Italy unfortunately remains behind, as always, but there are examples of excellence. The pioneering medical research of Professor Enrico Facco of the University of Padua recently led to the use of hypnosis in a surgical procedure for removing a tumor from a young woman allergic to any type of medication".

One of the key messages that emerges in your book is that the unconscious defines us as individuals much more than our conscious part does. The idea is that we need to stop thinking of the unconscious as something outside ourselves, that does not belong to ourselves.
"Fathers of contemporary neuroscience such as Eric Kandel and colleagues at Columbia University in New York claim that "the control of our actions is predominantly unconscious". Some estimate that about 90% of brain activity happens almost without the knowledge of our conscience. To stand firm in the blessed illusion that Man's most distinctive factor is precisely the part that has the least importance in all that we are is like insisting on living in an abstract reality. This is very clear: just look at what happens when we want to make a rational decision, put it into practice and keep doing it; or when we fall in love or have some feeling for or about a particular person or situation. On several occasions in the book, I describe how the unconscious, rather than being just a dustbin as once believed, represents a storehouse of resources useful for our survival. One of the most interesting features of our unconscious is the protective one: it protects us, for example, when it makes us feel the emotion of fear even before the conscience can identify the danger, putting us in the operational readiness to react, giving up on or facing down a situation. It is really a pity that we insist on wanting to stay on the tip of the iceberg. Certainly it is a convenient position if we pretend not to be completely responsible for our actions…".

This moved you to say that people should be considered "wholly and fully" responsible for their own unconsciousness, clashing with those who believe that less and less responsibility should be attributed to the individual, inside and outside the courts.

"In my view, we are responsible for our unconscious, since it is our own unconscious and not someone else's. In the same way, my brain is my own one, not someone else's: and I am fully responsible for it. Of course, if we thought we were only our conscious part… Here is the point. Who are we? Who do we want to be? These are not trivial questions, even though they may appear so. Is it enough to be just a piece of us? And the rest, do we cast it into the sea? Do we free ourselves from it? In what way? Rather, we should find a way to extend awareness also to unconscious regions, in a form other than the conscious one, still to be experimented, to look for, to find. Without having to reinvent the wheel, because a road already exists and is that of hypnosis".

What, more than anything, did you get from the writing of your book and what do you think the reader can acquire by reading it?
"Well, writing a book is always a process of growth, because it helps to systematize information, which we have today in industrial quantities but extremely fragmented. It helps to investigate concepts fully, identify the keys to the whole, make it all one organic work, and not the usual



collage, as happens for example in books written by several different authors. Compared to other colleagues, I think I have another advantage, apart from the ones mentioned at the start of the interview: At a certain moment of my professional life I moved onwards by myself, like a dog let off the leash, in order to not have to answer anyone except my patients and readers. This freed me from mediations and opened me to continuous exploration with the scientific method to the unknown, that in this field is still the majority of the research work left to do. In this way you can preserve intellectual honesty and affirm, as a clinician, scholar and independent researcher, what you think is valid and useful for people who are in need and ask you for help. Hypnosis is a powerful method to find the "strength within", to free oneself from any manipulation, rediscovering one's own vital autonomy. It can bring us to leave forever that chronic and needy existence that has backed us into a corner which is harder and harder to get out of with each passing day. Hypnosis, as I intend and use it, is therefore a practice of freedom and an ethical choice. And, as is done with poetry, I finally leave to each one the pleasure of drawing from the book the most suitable and useful message for themselves".

* Francesco Margoni is postdoc researcher at the Department of Psychology and Cognitive Sciences of the University of Trento. He holds a degree in psychology and another in philosophy, as well as a Ph.D. in developmental psychology. He is mainly interested in investigating the concepts of authority and morality possessed by infants, the cognitive mechanisms that can explain their acquisition and development, and how moral judgment changes with aging.

Francesco Margoni

The Future of the Newsletter

I do not believe that the newsletter is the best method to communicate with our members, and I do not believe that many members read it. We have approximately 350 members, and I think <10% read the newsletter - ie <35 people.

Is the editing and printing process worth it? I have alternative ideas, but would love to hear your views. Please contact Hils - natoffice@bscah.co.uk

Diary Dates
We've tried to cast our net wide in this list of diary dates. If you have dates for submission for next year's newsletter, please send them in! For more details on any of the events, get in touch!

Foundation Course
Northern Counties: 26/27 January, 23/24 February, and 23/24 March 2019
Mets & South (London): 26th-27th January 2019, 23rd & 24th February 2019, 23rd & 24th March 2019

Advanced Professional Diploma
BSC Course in Hypnosis and Related Techniques, Midlands
Module 1:27th - 28th Sept 2019 Module 2: 23rd-24th Nov 2019
Module 3a: 7th-8th Feb 2020 Module 3b: 6th-7th March 2020

PGCert Hypnosis in Research, Medicine and Clinical Practice
7/8/9/10/11th of Jan 2/3 Feb, 16/17 Feb, 6/7 April 2018.

December 2018:

Easing past trauma without drama, London 8/12/18
https://www.eventbrite.co.uk/e/easing-past-trauma-without-drama-tickets-49178623587

RSM Hypnosis and the placebo effect and the David Waxman memorial lecture 10/12/18

2019 Dates

February 2019: AAGBI Medical Hypnosis introduction 4 Feb 2019

https://www.aagbi.org/sites/default/files/Medical%20hypnosis%20programme%202019.pdf

March 2019: The Anxious Patient, Lancs & Cheshire 3 March 2019
RSM Hypnosis in woman's health 11-Mar-19

POEMS for Children Newcastle, https://www.poemsforchildren.co.uk/ 29/03/19
Paediatric Sedation and Anxiety Management - SAAD/BSPD Dental Day

https://www.saad.org.uk/index.php/component/vikevents/?view=event&itid=44 23/03/19

April 2019: RSM The Elliotson prize and lecture 15-Apr-19

May 2019:

POEMS for Children London, https://www.poemsforchildren.co.uk/ 10/05/19

June 2019: **BSCAH national conference 7th, 8th & 9th June**

September 2019: 25th World Congress of Psychosomatic Medicine 11th- 13th Sept 2019
It is about physical and mental health of males and females of all ages. The topics are wide-ranging from clinical subjects (Medicine, Surgery, Obstetrics/Gynaecology, Psychiatry) to pure science and Philosophy. Abstracts are being invited for presentation and also for workshops and symposia.
http://www.icpmonline.org/25th-world-congress-florence-2019

RSM Hypnosis in paediatrics and child health 16th Sept 19

October 2019: BSCAH Oncology workshop 19th Oct 2019

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