BRITISH SOCIETY OF CLINICAL AND ACADEMIC HYPNOSIS
NEWSLETTER

Niagra Falls - we never know what turbulence is ahead, or what turbulence lies behind others.

Stress and Resilience Theme

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http://www.bscah.com

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@BSCAH1

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Medically Unexplained Symptoms

I (Charlotte) recently attended a simulation course on medically unexplained symptoms. It was a good day where we went to speak to an actor, with MUS, and worked through the communication needed. We then talked a lot about MUS. Here's some of the things I learnt:

Remember to take a functional history - look for the therapeutic and physical. Ask about depersonalisation / derealisation and physiological or psychosocial triggers.

If you are about to suggest it might be MUS, pre-empt -"I can see what I'm about to say may be strange" and then explain. A label does help patients, although they prefer the "label" persistent physical symptoms or functional disorder. Normalise the abnormal straight away - tests NAD, but that's the case with about 50%.

Risk Factors - past history of MUS, stressful event, long term conditions, adversity / abuse, recent infection.

MUS often starts after a physical trigger (often not significant) ----> an emotion perpetuates ---> ongoing symptoms. We need to change how the emotion perpetuates. To manage MUS, start by telling the patient about MUS. Then, treat co-morbidity, encourage sleep hygiene, provide stress management and encourage the patient to focus more on good days, and less on bad days. There are helpful internet sites for patients, and for providers - the R Coll Psych is one.

Remember that just sitting is a higher level skill.

Editor's Notes

The astute amongst you will have noticed this newsletter is late. I apologise profusely - a new house with no internet access has hampered my newsletter efforts. I do, however, think we still have a very interesting newsletter for you to read.

We've continued to cover a cause for "medically unexplained symptoms", with brucellosis being featured this time. We've tried something new, and this issue is a "stress and resilience" themed issue. There are 20 members on the BSCAH referral list who have listed "stress" as a specialty. This issue has tips from some of them on how they treat stress. I contacted everyone of those 20 members, and most ignored me. Some felt they did not know enough about stress to write anything.

This begs the question - how do you decide what your specialty is? Do you need to do extra CPD in this area? Do you need to know a fair amount about it? What do you think?

We'd like to continue the "themes" next time with dental phobia being our theme. Please can you suggest some themes for the issue afterwards, and contribute any articles on dental phobia, or hypnosis in general.

Very excited to read all your articles,

Charlotte Davies

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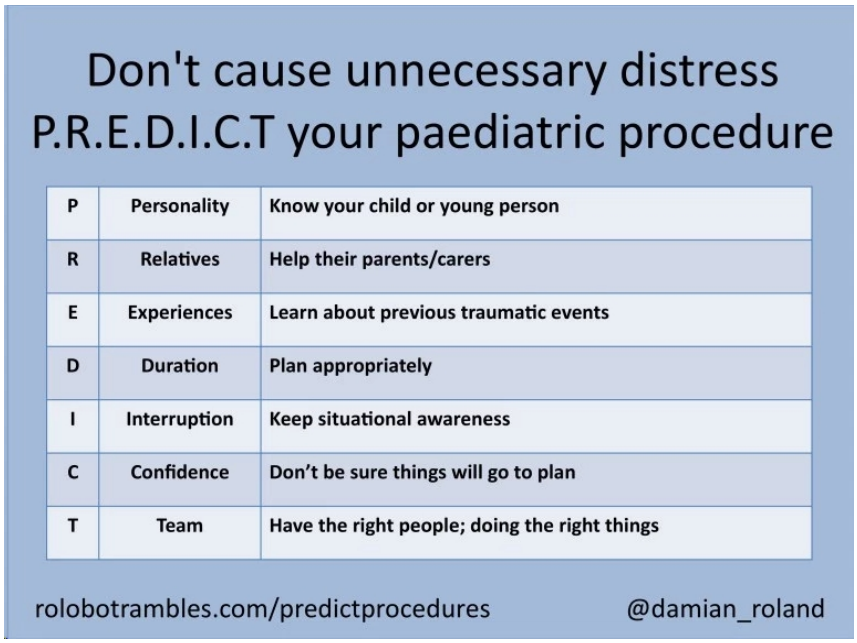

A paediatrician from Leicester writes weekly blog posts on "what I learnt this week". Although based on medical procedures, I wonder if it could be applied to hypnosis too? We don't just treat the young person. Or do we?

Some of us use hypnosis for procedures, and PREDICT could be very useful to help us remind what we need to do.

What do you think?

Northern Counties Branch Report

Grahame's April report was received by my "Spam" box before the deadline for the last newsletter. He has merged his April and July reports, so you are not missing out any information. Many apologies to Grahame for omitting it last time - Editor.

We completed our 2016 York Foundation Training, fully subscribed, and very well received. Gill Smith co-presented again. Leslie Walker and Graham Temple were popular guest speakers on Module 3.

Gill has moved to Edinburgh. It is still on Northern Counties 'patch', and reminds us that we should look to serve our members North of the border. She is actively exploring this along with Jane Boissiere.

Our Spring meeting on 12 March saw Jacky Owens doing PNI plus Gill Smith with a taster on Compassion Focussed Therapy as a trailer for a future workshop.

The 2016 joint meeting with Lancashire and Cheshire on 2nd July was 'Such stuff as dreams are made on ...' was successful and received excellent evaluations.

Dr Caroline Horton, from Bishop Grosseteste University Lincoln, enthusiastically presented on the science of dreaming and dream-wake continuity. She considered the role of dreams in memory consolidation and hinted at the direction her active research might take in the future.

Annie Rowley, the chaplain to York St John University, formerly working at The Retreat, did a workshop introducing us as to how to help people work creatively with their dreams. The two presentations complemented and contrasted with each other very well.

We are looking to arrange another joint meeting in Summer 2017.

We are fortunate in having low expenses at The Retreat and sufficient Branch funds to provide meetings free to our Branch members, and nominal fee to others, as a benefit of membership of BSCAH. Thanks to Dan Round for facilitating this.

Future meeting dates are 12 November 2016 and 4 March 2017. Several topics are in the melting pot. Details will appear on the website as we finalise them.

We plan to run 2017 Foundation Training on 28/29 Jan, 18/19 Feb, and 18/19 March at The Retreat, York. Grahame Smith (grahamedsmith@doctors.org.uk)

The unique selling point of BSCAH - from the perspective of a psychotherapist

Under the editorship of John Gruzelier, our journal, Contemporary Hypnosis, changed its name to Contemporary Hypnosis and Integrative Therapy. This title, which has been retained, is important because it helps us to understand not only the purpose of the journal, but also of our Society as a whole. The journal title reflects the fact that we are interested in both hypnosis as a phenomenon in the laboratory setting, as well as in clinical practice.

The efficacy of psychotherapy, when used appropriately, can be enhanced greatly by hypnosis. However, psychotherapy can take on many forms. For some, psychotherapy is an extension to counselling psychology, while for others - usually members of the psychoanalytic community - it is a discrete therapy which should be used in isolation. Protagonists of integrative psychotherapy have pointed out that a tailor-made approach to treatment - combining psychodynamically-oriented psychotherapy with behaviour therapy, and also hypnosis - helps patients to deal with the source of their problems and help equip them to move on in their lives. I believe that this approach to treatment can be utilised by skilled practitioners in the field - by psychotherapists, doctors, nurses, counselling and clinical psychologists and other health professionals who have had the appropriate training. In conclusion, I believe that integrative psychotherapy, which is utilised by a large number of BSCAH clinicians, should play an important role in health care. It is for this reason that it should be added to our 'unique selling point'.

David Kraft

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What do you think BSCAH's USP is? Why should prospective members join us? Why are our training courses the best? Why are you a member of BSCAH? Let me know!

www.fabnhsstuff.net is a great online repository of ideas and projects. It's a great way to learn about something new, or to share your great ideas and projects. You might be interested in online psychoeducational courses, advertised through fabnhsstuff: http://fabnhsstuff.net/2016/05/19/online-psychoeducational-courses/. It is a CBT based psychoeducational online course that people can access anywhere where they have an internet connection. 98.6% of people felt that this course gave them help that mattered. Would you recommend an online CBT course to your patients?

Brucellosis

I thought your reminder that MUS are just that... unexplained (yet), was very good. We should all remember that a physical cause can emerge, CO poisoning being an excellent example. I regularly mention this on the foundation course. Another one is brucellosis.

Also from 'them days' lead poisoning , though there used to be some element of hysteria about leaded fuel when a leading cause was actually kids playing where old car batteries had been dumped. Memory lane was not necessarily idyllic. Has there been any return of 'pink disease'? Grahame

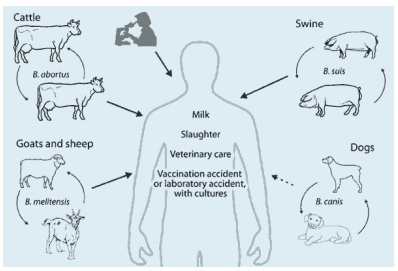
Brucellosis is a common question in medical exams, but is not something I have seen in “real life”. If you’d like to know more about it, BMJLearning offer an online module, which is free if you have an athens account. Sorry if you don’t - the FOAM (free open-access medical education) hasn’t covered it yet.

Brucellosis presents with non-specific features, and is rare in Western Europe and North America. It is rarely fatal (5% mortality rate, mostly from endocarditis), but can be debilitating and chronic. It is endemic in India with high rates in Middle Eastern countries, the former Soviet republics of central Asia, parts of Latin America and most Mediterranean countries.

It is contracted from consuming unpasteurised dairy products (raw milk, soft cheese, butter, ice cream) or occupational exposure (inhalation and direct contact). The incubation period is two to eight weeks.

Symptoms are varied and vague with the most common being fever (74% of cases) and constitutional symptoms (26%) like malaise, anorexia and night sweats. Hepatomegaly and splenomegaly (large liver and spleen) are found in about a third of patients. Maloderous perspiration is almost pathognomic. Peripheral neuropathy, pleural effusions, pneumonia and endocarditis can also be present.

It is diagnosed on blood cultures which only have a sensitivity of 20 - 80%. Serological tests are available in some centres. Bloods might show leucocytopenia, lymphocytosis, thrombocytopenia or anaemia.



Treatment is with doxycycline and rifampicin for six weeks.

Primary Care Ramblings…you have to be careful!!

Having become increasingly frustrated and disappointed with the provision for mental health in Norfolk I embarked on my training in hypnosis sometime in the early nineties.

I quickly became a total devotee and plunged in treating anxiety, panic disorder, social phobia, health anxiety and a whole lot more.

One interesting case was a young woman who was a health professional. She was very anxious and often totally tortured with fears of serious illness. It was usually a fear of cancer either internally or on the skin and she also had quite severe eczema. She had very low confidence in herself always preoccupied with her fears. However, she was a determined person, was married with a small child and was still carrying out her busy role at the local hospital.

She was a good subject and I spent time during the hypnosis sessions doing ego strengthening building her confidence in herself as a strong , healthy young woman in the prime of her life. After five sessions, she was a lot better and went away feeling calmer and much more confident.

About a year later, she came in for a sick note having just undergone an appendicectomy. When I read the operation note it mentioned that the appendix was gangrenous and she was lucky it hadn't ruptured. She explained that when the abdominal pain began, she just assumed it was all in her head, that she couldn't have anything wrong as after all, she was a perfectly healthy young woman and waited two days before going to hospital!! Oops.

Another patient was a very anxious man, working as a security guard. He was slightly built and hated confrontation so maybe in the wrong job??

Anyway, in the hypnosis sessions I did a fair amount of confidence building and suggestions about feeling calm and relaxed under pressure. He came in a few months later complaining bitterly that I had made him so calm and confident that he confronted a man who was brandishing a gun! Happily the incident passed off without loss of life or injury but I had a strong impression that he blamed me for his foolhardy behaviour. You just can't win.

As many of us do, I usually ask the patient to come up with their own imagery before

starting the induction. Just simple eye closure and ask what would their place of peace be like. Sometimes it is the usual beach but often they choose a more dynamic location: one was standing in the Indian Ocean, water at chest height and feeling the powerful swell of the water. One, an avid sailor was sailing a dinghy out of Poole harbour and felt the sudden rush of the wind catching the sail, giving him a sense of power and control. If we are dealing with pain or a disease process I ask them to consider what their immune system would be like in order to deal with the illness. This has produced the most fantastic variety of imagery which I would not have come up with in a million years. They have ranged from a disembodied elephant trunk hoovering up the pain, thousands of green pac men whizzing around the blood stream looking for tumour cells to gobble up and a cool blue liquid pouring out of the crown of the head and travelling down the body enveloping the painful limb. One man had an army of commandos doing battle in his prostate gland.

It's all gloriously creative and amazing. Maureen Tilford

A Call to Members!

When BSCAH ran exhibition stands at various conferences we were constantly being told by delegates that they were curious about hypnosis and wondered how it might fit in with their clinical work. That is why we have launched the one day taster workshops targeting specific clinical fields. These are proving quite popular as busy health professionals are more able to attend a one day workshop and this type of CPD can often be funded by external sources such as pharmaceutical companies. A few participants do go on to do the Foundation training or the Birmingham Diploma/BSc but at the very least all participants learn self-hypnosis and are educated about hypnosis and the powerful effect of the words they use.

The present group of people able and willing to run these taster days is small, and we need to increase the number of members who can help. Older members need to pass on their experience and expertise to younger members so that BSCAH can continue to fulfil its educational role. Many members are happy to give their time freely, but BSCAH feels that they should have some recompense so they do.

Do you feel passionate about hypnosis and want to tell your colleagues about it? Does the idea of becoming a trainer interest you? Would you be prepared to attend a Trainers Training weekend? If so, then please contact Ann Williamson (ann@annwilliamson.co.uk) or Jane Boissiere (admin@bscah.com).

How I treat my stressed patients

Introduction

I have been a partner in a busy GP practice for 33 years, retiring last year, and have used hypnosis privately and with NHS patients during that time. I trained with the Medical and Dental Hypnosis Society whilst a GP registrar over 35 years ago, whilst I was pregnant with my first child. I had both my children with the aid of hypnosis. I later obtained a Diploma in Applied Hypnosis from UCL.

About 15 years ago I reduced my hours in general practice in order to concentrate more on my hypnosis practice. I found that many of my stressed patients enjoyed talking in depth as well as the experience of deep relaxation through hypnosis, so I decided to pursue a part-time postgraduate Diploma in Counselling and I feel the combination of counselling and hypnosis has greatly enhanced the way I deal with stressed patients and has considerably improved results. I would strongly recommend fellow hypnotherapists to consider undertaking a qualification in counselling to augment their practice.

My counselling course was interesting and hugely enjoyable and I felt that I benefited personally from the experience. It is expected, though not compulsory, that as a student you undertake some counselling or psychotherapy yourself, which I did, and found it to be a hugely rewarding experience. In particular, understanding the need for silence and experiencing what it feels like to be a patient or client. I was fortunate to engage an excellent psychiatrist/psychotherapist who has greatly enhanced my practice and has enabled me personally to grow. Some patients come for hypnosis and I introduce the idea of some person-centred counselling or CBT, others attend for counselling and at some stage I introduce them to the idea of hypnosis as a tool they can learn and use themselves at home.

My methodology

I always speak to my patients on the telephone before confirming an appointment. At this time I am able to start assessing their problems and by talking with them I find it establishes a rapport and begins the therapeutic process. It is a process of mutual assessment and determines whether we would like to work together. I explain broadly the plan…the cost of each hourly session, that they need to plan for 3 - 4 sessions over a period of 4 - 6 weeks and that further sessions may be arranged if

required.

The first session is taken up with exploring the problems. Many of my patients are extremely stressed and anxious and many are experiencing full-blown panic attacks. I start by reassuring them that their problem is common and that I deal with it a lot. This reassures them that they are not unusual and are not going ‘mad’ and that we have a good chance of success. I spend some time explaining the ‘flight or fight’ response first described by the eminent Harvard psychologist Dr Walter B Cannon in 1915. He became interested in the physical reactions of laboratory animals when under stress. When our fight or flight response is activated a sequence of nerve-cell firing occurs and chemicals such as adrenalin, nor-adrenaline and cortisol are released into our bloodstream.

The ‘flight or fight’ response, or ‘acute stress response’ is an automatic reaction to a stressful and potentially dangerous situation. Our brains react quickly to keep us safe by preparing the body for action. By explaining this response and getting my patients to ‘make friends’ with it and to realise it is their body trying to keep them safe, they immediately become less frightened by the feelings.

I find the easiest way to explain it is to ask my patient to imagine they are a primitive caveman only having other cavemen or predatory animals to fear. In order to fight or flee either of these, they need…

- An accelerated heart rate in order to provide their required blood supply to their muscles.
- An increased breathing rate to take in more oxygen to supply their organs and muscles.
- Inhibited bladder and bowel action (so we often feel an initial desire to empty our bladder or bowels so that we are comfortable fighting or fleeing).

In addition…

- Our pupils dilate, making us look more frightening to our enemies.
- Our impulses and reactions quicken (which can make us hyper-alert and jittery).
- Our perception of pain diminishes.

When we face real danger, these responses are invaluable but when we feel stressed due to work or emotional pressures (the modern wild animal) our fight or flight system still comes into play with resulting and alarming feelings.

If not properly metabolised excessive stress hormones in our body accumulate and lead to disorders of our autonomic nervous system causing, for example, high blood pressure, headaches and gastrointestinal problems and sometimes even disorders of our immune system leading to susceptibility to infection. Sometimes depression or maybe some auto-immune diseases. By recognising these changes as they happen in their bodies my patients become less frightened by them; start to accept them and very quickly (sometimes within a week) start to experience them less.

I then invite patients to experience an introductory session of hypnosis in order to attain a deep relaxation. I find that patients relax more fully lying on a couch. I use simple eye fixation and heaviness for induction followed by progressive muscular relaxation emphasising that they will feel more deeply relaxed with every breath as they breathe out. I then use Hartland's arm heaviness/lightness/automatic movement for deepening[1], followed by his ego-strengthening routine which empowers the patient to feel in control. I then take them 'in their imagination' to a place of safety and relaxation that they have chosen in our introductory chat time. This is often a sunny beach/sea image or a lovely garden or even sometimes lying on their bed or sofa at home.

When in that place I use 'sensory cues' to deepen the hypnosis eg…'you can feel the sand under your feet…as you walk to the water's edge, you can feel the cool water lapping up over your feet and the warm sun on your body like a comforting blanket' or, if in a garden…'look around at the beautiful flowers, so many different colours…red roses, bright blue delphiniums…etc.' Then at some point, when I sense from their breathing and appearance that they are pleasantly relaxed I suggest they lie down (in their imagination) on a sunbed/sofa/bed…'and feel the pillow under your head' (remember they are lying on a couch with a pillow in my consulting room). Then I introduce the idea of plucking a fluffy cloud from the sky and pulling it down onto their lap (even if they are on their bed at home they can reach through the window) I then encourage them to put all their worries and anxieties in the cloud; anything that has been bothering them, feelings, worries, people, situations, etc.

After a few minutes, when I suspect they've finished filling the cloud, I suggest they

tie the cloud closed with a big knot, lift it up and watch as a gentle gust of wind carries it away…'higher…higher…further…further, so it gets smaller and smaller as they watch it until, MAYBE, it becomes so tiny that it disappears altogether'. Although this imagery may sound strange, it is surprisingly popular with patients.

Post-hypnotic suggestion

I invite patients to realise how relaxed they feel and then I give them a post-hypnotic suggestion stating that when they wake the relaxed feeling will stay with them, 'for the rest of the day, tonight, tomorrow and maybe many days, weeks and months ahead'. I suggest that now that they know how to relax, they can remain relaxed in all situations, in all places, etc. (I sometimes suggest specific situations, if the patient has given me that information) I then give a further post-hypnotic suggestion that the next time they come to see me again for hypnosis; when they lie down on the couch and hear me count from 1 to 5 they will fall into a pleasant hypnotic state 'much faster, much easier, much deeper' and be more relaxed than when they first came to see me. I then wake the patient by counting backwards from 5 to 1 suggesting that when they wake they will feel relaxed, but 'wide awake and fully alert, able to drive safely and carefully and remain awake until such time as they wish to sleep'.

Further sessions

I tell patients that I will tape-record the next session for them to keep and listen to at home. I use a low-tech audio-cassette tape as this seems to suit most people, and cheap small tape-players can still be purchased easily on the internet. Some of my younger more media-savvy patients allow me to record directly onto their I-phones. They can also alter what they choose to put into their 'cloud' as their situation changes.

One patient I saw a few years ago had a very difficult relationship with his oppressive and dominating mother…he reported that despite his best attempts she kept climbing out of his cloud!

Dr Janet Taylor

MBBCh Dip Appl Hypnosis , Dip Counselling

Reference: (1) Hartland's Medical and Dental Hypnosis, 3rd edition, 1998, David Waxman. Balliere Tindall

Building Resilience

It appears a fact that some people are intrinsically better able to handle stress and crises than others. Why is it that one individual can 'bounce' back from disaster whereas another collapses and goes under? Some people appear to be naturally resilient and others not. This can also be applicable to communities facing natural or man-made disasters. "When applied to people and their environments, 'resilience' is fundamentally a metaphor"[1]. Those people who struggle and fail to overcome adversity tend to be the ones we see. Hypnotherapy is one of the more effective tools to help individuals in this second group to regain mental and physical wellness. Using imagery (among other techniques) and boosting self confidence, hypnosis can assist patients to develop constructive solutions to their difficulties, and build their resilience to present and future stress events. As professionals using hypnosis we already know that metaphor plays a key role in much of our work, and that the success of our interaction with patients is often the direct consequence of the power of deliberate metaphors.

But what exactly is 'resilience'? Here is a quote from an American pastor:

"People who soar are those who refuse to sit back, sigh and wish things would change. They neither complain of their lot nor passively dream of some distant ship coming in. Rather, they visualize in their minds that they are not quitters; they will not allow life's circumstances to push them down and hold them under"[2].

In a study of resilience among Native American Indians one of the authors, Heavy Runner, says:

"Resilience is the natural, human capacity to navigate life well. It is something every human being has - wisdom, common sense. It means coming to know how you think, who you are spiritually, where you come from, and where you are going. The key is learning how to utilize innate resilience, which is the birthright of every human being. It involves understanding our inner spirit and finding a sense of direction"[3].

Some researchers, however, distinguish 'resilience' from 'resiliency'[4], arguing that resiliency is an individual inborn trait or characteristic, whereas resilience is a dynamic process that can be learned through ego-boosting techniques, finding new ways to overcome adversity, reduce the effect of risk factors, and break negative

cycles of thought and behaviour.

Perhaps the patients we see are not the ones with innate resiliency then, but the vulnerable ones who need psychological, practical and spiritual help to fully engage in that dynamic process. Milton Erickson was a master in building resilience through using metaphor to imply the growth and unfolding of his patients' inner strengths to overcome their perception of "helplessness".

It is useful to consider actively building resilience as well as treating 'problems' – and many professionals do this anyway whenever they use ego-boosting techniques; however, ego-boosting per se may not be enough. Building resilience in the face of adversity will always need to be focused on each individual's specific strengths and weaknesses, and tested out in real life. To consolidate this new resilience the therapist may end up co-directing the journey with the patient for a longer time than anticipated. It may take longer with such patients who do not have 'genetic' resiliency.

Greta Ross

References:

1. Charles Swindoll (US Evangelical Christian pastor)
2. Norris F, et al. 'Community Resilience as a Metaphor, Theory, Set of Capacities, and Strategy for Disaster Readiness', online. 2007
3. HeavyRunner I, Marshall K. "Miracle survivors": Promoting resilience in Indian students. Tribal College Journal. 2003;14(4):14–19
4. Fonagy P, et al. 'The theory and practice of resilience'. Journal of Child Psychology and Psychiatry. 1994;35(2):231–257

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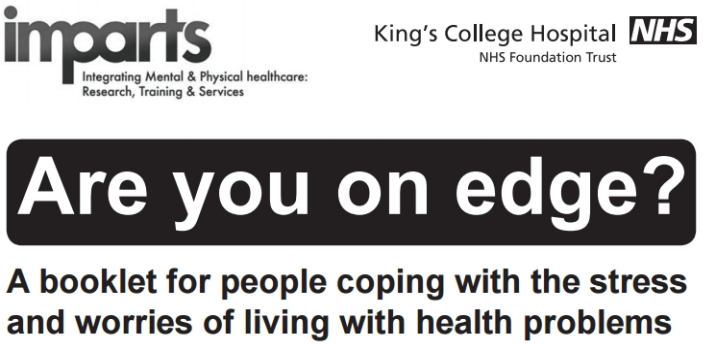
With access to the internet, and limited resources, there is a lot of self help material online. King's College London has made a lot of their self help material freely available for anyone to use here - http://www.kcl.ac.uk/ioppn/depts/pm/research/imparts/Self-help-materials.aspx. If you use it, they'd like to know what you think of it! One of their leaflets is on Stress - it's worth a read. It talks about how normalising anxiety and stress is part of acceptance.



“Acute Stress” and Resilience

I have spent a year facilitating high fidelity simulation for medical professionals. Simulation involves a simulated patient scenario. The “patient” is often portrayed by a mannikin which can speak, breathe, have heart sounds etc. and the environment is kept as realistic as possible. Clinical scenarios are limitless but are normally around the peri-arrest (about to die) patient. The candidate has to treat the patient, with the help of their team, whilst everyone else watches. After the scenario we then perform a structured debrief, with the aim of highlighting some non - technical, human factor skills. This debrief is learner lead. The learners frequently mention that the scenario makes them feel “stressed”.

So, how do we manage this “acute stress”? Counselling and psychotherapy aren’t what’s needed for most people, and the acute stress response may even be beneficial. Here are the suggestions we give in our debrief - I’d love to hear any more.

Nuts - Training - Stress - Step 1 - 2 - 3

1. **“Nuts”**

   Recognise your stressors. What stresses you out? Things normally fit into four broad categories: “NUTS”. Novelty, Unpredictability, Threat to Ego and Sense of Control Loss. Once you’ve identified your stressors, can you reduce them?

2. **Stress Innoculation Exposure Training**

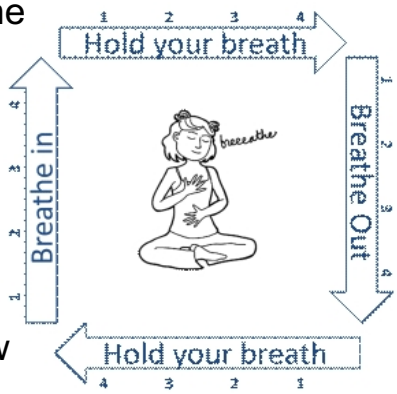
   Educate yourself on how to deal with stress, practice stressful situations, prepare yourself, and then apply it.

3. **STRESS**

   Self Aware - Acknowledge you are stressed. Let your team know. You may need to look for the “BEST” signs of stress - behavioural fight and flight, Emotional anger and irritability, Somatic sweating, Thinking and tunnel vision.

   Take Ten - no-one dies because you spent ten seconds taking a breath in. Use this time to gather your thoughts. This might be a mental pause, or a physical pause where you take yourself out of the situation.

Relaxation Techniques - this could be physiological or cognitive relaxation.



Do some square (or tactical) breathing - breathe in through nose for four seconds, hold for four, exhale for four, hold for four. This is a more focussed strategy than "take a deep breath" and seems to work more effectively.

Cognitively relax by reminding yourself that stress is good. Say hello to stress! We all know that optimal arousal (not to low, not too high) can lead to optimal performance - stand up straight (utilising positive body language) and embrace it!

Evaluate Stressors - and remove them if possible. It might be that you are "HALT" (hungry, angry, late or tired) and most of these are easily remedied. You might need to message someone you argued with, and tell them you love them to stop it playing on your mind and contributing to your stress. You might need to eat.

Support - ask for help from senior and junior colleagues including different specialties, and different professions.

Self Care - build your resilience

4. Debrief and Consider

Always debrief after an incident, whether you found it stressful or not. Think about why you found it stressful or why you didn't.

S	Self Aware	Identify you are stressed "BEST"
T	Take Ten	
R	Relaxation Techniques	Physical and Mental Pause (Cognitive and Physiological Control)
E	Evaluate Stressors	"STAR"
S	Support	
S	Self Care	"REST"

5. Build your Resilience

Resilience isn't how much it takes to break you, it's how quickly you bounce back after being broken. Palm trees are very resilient - the wind blows them nearly horizontal, but they spring back up again. There's lots of different components to being resilient, and you need to look at all of them. You need to reach "ikigai" and balance out what you are good at, with what you love, pay, and what the world needs. Here are some practical tips to help you address all those areas:

a) Lifestyle

- practice straightforward communication with people, and saying what you mean.
- relax and enjoy things. If you couldn't do it without your professional registration, it's not relaxing.
- make time for your friend**s**
- book a holiday so you can always move, like Tarzan, from one holiday to the next.

b) Physical Health - "REST"

- Regular breaks - on shift and off shift
- Eat Well
- Sleep well
- Train / Exercise

c) Give yourself a break

- Reward achievement - congratulate yourself on the things you've done well.
- Book a holiday - make sure you can swing from one holiday to another.
- Resolve conflicts in your professional and personal life.
- Out-source anything that you can. Get a cleaner. Accept help from your friends. Get a gardener. Stanford hospital pays overtime not only in monetary terms, but in "out-sourcing"

terms. If you work overtime, you get meals provided or your washing done.

- Don't sweat the small stuff. It's annoying when things don't go to plan, but is it helpful for you to try and make it better?

d) Look after your own mental health

- Be positive and look for the silver lining
- Use humour
- Give things a lack of permanence "my boss didn't like that piece of work" is better than my boss never likes my work.

e) Appraisal and Support

- Talk about appraisal and make sure it happens
- Tell your friends what's happening
- Use all your resources
- Share your experiences

Charlotte Davies

References and further reading

All of these references are linked to online on one webpage. The content written about is also talked about in two "microteach" sessions, also available through the blogspot.
http://humanfactorseducation.blogspot.co.uk/search/label/resilience
http://humanfactorseducation.blogspot.co.uk/search/label/stress

Microteach: Resilience: https://vimeo.com/162826568 Stress: https://vimeo.com/155434253
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http://icenetblog.royalcollege.ca/2016/02/19/keylime-ep-103-meded-and-the-poison-of-loneliness/

Who Accesses Clinical Hypnosis Services in an Oncology Department, Why and What do They Think About it?

I have been running an ad hoc Clinical Hypnosis clinic, for oncology patients, at West Suffolk Hospital in Bury St Edmunds, for over 4 years. As part of the process to get a formal clinic commissioned I have undertaken a survey of patients attending the Oncology and Haematology Department, to ascertain the potential demand, kept a log of the reasons patients have been referred to me for Clinical Hypnosis and completed a satisfaction survey of patients who have accessed the service.

Survey results

75 questionnaires were distributed to patients attending an oncology or malignant haematology clinic with 54 being completed. Just over half the responders were female and 50% were between 50 and 70 years of age. The majority of patients had breast cancer (46%), prostate cancer (22%) or lymphoma (17%). Patients were split evenly between those who were attending for potentially curative treatment, those attending for palliative treatment and those who had completed treatment.

15(28%) patients would definitely have hypnosis; two thirds of these were female and a third male. There was no trend regarding age or stage of cancer. 21 (39%) patients said they might consider having hypnosis. There was no difference between the sexes, age or stage of disease. 16 patients would not consider hypnosis with no pattern regarding age, diagnosis or stage of disease. Patient reasons for not considering hypnosis fell into two groups; those who considered they did not need it and those who had fears about their mind or free will being interfered with. The more understanding a patient had of hypnosis the more likely they were to wish to use the service: 81% of those who would not consider using a Clinical Hypnosis service said they knew nothing about hypnosis.

Anxiety, depression, smoking cessation, pain management and insomnia were the conditions that were most commonly thought to benefit from Clinical Hypnosis, with the treatment of phobias, weight loss and Post-Traumatic Stress Disorder also strongly associated with its use.

Reasons for referral

Over 40 patients have attended for Clinical Hypnosis. A few had short interventions

within a routine clinic slot with the rest attending formal hour long sessions. Referrals come via me offering Clinical Hypnosis to a patient attending my Oncology Clinic, the Clinical Nurse Specialists in the department and, increasingly, fellow consultants. Patients have attended due to factors affecting their tolerance of investigations (such as claustrophobia) or treatment (needle or tablet phobias and treatment-related side effects, mainly nausea and vomiting, and menopausal symptoms). Anxiety, depression and insomnia are also common reasons for referral. Pain management, whether from cancer-associated pain or pain from benign conditions affecting their ability to tolerate radiotherapy or to live life to the full, has also been a reason to offer Clinical Hypnosis. Many patients bring issues from their 'pre-cancer life' to the sessions, the resolution of which enables them to tolerate treatment or to move on with their life after successful therapy.

Out of the first 33 patients, 17 (52%) were offered hypnosis for hot flushes brought on by treatment for breast or prostate cancer of whom 9 had other issues such as depression, pain and phobias that impacted on them. For 6 (18%) the presenting issue was chemotherapy induced nausea and vomiting, 3 (9%) were pain, 2 anxiety (6%), 2 depression (6%), 2 insomnia (6%) and 1 panic attacks (3%). In total 17 out of the 33 patients (52%) had more than one issue for which they wanted to use Clinical Hypnosis even though a single issue might have been the trigger for referral.

Patient Satisfaction

Twenty- four questionnaires were sent out to living patients who had received at least one, full, session of Clinical Hypnosis. There were 12 replies (50%). Patients had attended for a mean of 2.4 sessions (range 1-5) and all would recommend Clinical Hypnosis to family and friends experiencing similar issues. As a result of attending the clinic patients felt more able to cope with their situation (mean score 7.4 out of 10) and felt they had less need to contact their GP (7.5 out of 10) or the hospital (7.7 out of 10) because of symptoms or worries. Patients felt that their ability to cope with stress and anxiety (7.4 out of 10) or depression (6.9 out of 10) was greater and all bar one patient felt the symptoms, for which they had been referred, had improved.

The comments reveal more than statistics can and some of them are reproduced here. "I have to say that the self-hypnosis, which I still practice after 4 years, is an absolute godsend and I would thoroughly recommend it to anyone who may be sceptical of its power".

“The first session of hypnotherapy enabled me to complete the course of radiotherapy but it did so much more than that, it gave me coping strategies for many situations at a very difficult time. It is a remarkable tool. The second session gave me the ability to cope with the dreadful pain from a broken arm. I was able to manage the pain, which then enabled me to do the exercises necessary to get the arm moving. I am so grateful that I was able to have hypnotherapy”.

“I experienced a lot of nausea/vomiting with chemotherapy 17 years ago, but this time hypnosis helped relieve my fears and cope better”.

“I never previously thought that I would be able to do hypnosis. I was not convinced it would work for me. I was surprised when it did and how relaxed and pleasant the experience was. The three formal sessions I have had relaxed me and reduced the pain I was experiencing. I am now able to use the techniques given to me and do so whenever I feel under stress or in pain. I am delighted to have had the opportunity to undergo this treatment”.

“I think it is important to offer a treatment other than pharmaceutical ones. The ability to help yourself by taking part in Clinical Hypnosis gives you an element of taking back control of your own life after/during cancer treatment. I believe it is an important part of recovery and providing a clinic for this can only be a good thing”.

Discussion

Patients who have received a diagnosis of cancer have been shown to have high levels of psychological morbidity associated with the diagnosis and their treatment. 25% of women have clinically relevant anxiety one year post surgery for breast cancer whilst up to 81% of women receiving adjuvant (ie potentially curative) chemotherapy have anxiety, depression or other symptoms severe enough to be considered a psychiatric disorder. Three months after the diagnosis of a good prognosis breast cancer half of the women are clinically anxious and over a third clinically depressed5. Psychological issues are not just the domain of patients with breast cancer however, looking at patients with inoperable lung cancer a third were found to be clinically depressed shortly after diagnosis and this depression persisted[6].

There are many misconceptions about hypnosis within the general population fed mainly by sensationalist television and stage shows. Patients seek the help of

complementary and alternative medicine (CAM) to help fight the cancer and to improve physical and emotional wellbeing. With herbal and homeopathic remedies featuring highly on the list of CAMs taken by patients with cancer, the risk of interactions of both these remedies with conventional anti-cancer treatment and the desire to avoid polypharmacy, hypnosis is an attractive option to deal with many of the issues reported by cancer patients.

Two thirds of the patients attending our Oncology Department would utilise hypnotherapy services now, or would consider doing so in the future. The effectiveness of Clinical Hypnosis in the amelioration of treatment-induced menopausal symptoms is not widely known but is one of the most frequent reasons for referral for treatment and may help with treatment compliance. The use of hypnosis to help with phobias such as claustrophobia, needle phobia and vomiting phobia could potentially reduce delays and repeat appointments within the MRI department, reduce the need for expensive anti-emetics and speed up the phlebotomy and cannulation time in patients receiving chemotherapy or requiring CT scans. Help gained on the emotional front could have the potential to reduce demands on hospital staff and resources, as well as in General Practice, especially for issues based around anxiety and fear.

Conclusion

Many cancer patients would consider using hypnosis to help them through treatment-related side effects and cancer-induced symptoms. The main barriers to a patient accepting hypnosis seem to be lack of knowledge of the therapy and myths about mind control perpetuated by popular television. Those that have attended for Clinical Hypnosis sessions have found them useful, have adapted the tools learned to help with other issues that have happened in their life and would recommend Clinical Hypnosis to family and friends in a similar position. They have come for a variety of reasons, cancer or treatment related and unrelated. There would appear to be an unmet need for supportive therapies that give the patient a tool they can use to help themselves.

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Dr Cathryn Woodward
Hon. BSCAH Secretary

ESH 2017 Unlocking hidden potential…. Wednesday 23rd- Saturday 26th August 2017

Why not unlock your hidden potential and apply to submit an abstract for a presentation at this prestigious conference? This could take the form of a talk, a poster or a workshop and would look good on your CV! It is always good to hear from others about how they use and adapt hypnotic techniques in their work and we all learn from hearing the words and metaphors that others use and often incorporate these into our own practice.

So don't be shy – everyone feels apprehensive to some extent before making a presentation but this can mean that we hone our skills and take care of our preparation. Once in the flow of presenting material that you are familiar with, your unconscious mind can take over and allow it to become effortless and fluent. If you are passionate about your material then that enthusiasm will carry you forward and be transmitted in how and what you say.

The early bird rate will run until the end of February but abstracts need to be in by January – so don't delay – take the bull by the horns and do it now!

We are running some pre-congress workshops – including one on "Past Trauma" that is being run by Geoff Ibbotson and Peter Naish. We are having a public/media event between 2-3pm where we compare how hypnosis is portrayed in the media with how it is actually used in clinical practice. The Congress proper starts at 15.30 with an opening welcome address by the President of BSCAH and a keynote address from the outgoing ESH President Dr Consuelo Casula.

Following directly from the plenary session will be a Drinks Reception from 18.30pm (included in registration) during which we will be entertained by the tranquil sound of a harpist (those of you who were at the Drinks Reception at the Copthorne this year will remember how lovely it was!).

I am hoping that each day we can offer a pre-breakfast meditation session together with a T'ai Chi or Yoga session for those that prefer active meditation. I feel that this would be a good start to the day, but of course it would not be compulsory!

We already have a great variety of topics and speakers lined up for you and there will be a Gala dinner with entertainment (ESH has talent!) and dancing on the Friday. We will have more details and tickets available soon.

There are also plans to have a Northern Evening on the Thursday night with a Morris Dancing display for our European visitors followed by a Ceilidh – and I promise the dances will be simple enough so that those who haven't danced before can easily pick it up! We will have a live band and dinner will be included and dancing is great way to exercise and burn off those extra calories!

But if you just want to explore Manchester and sample some of our excellent restaurants and pubs or undertake some retail therapy we will have a variety of outlets advertised for you to choose from and various tours will be available. Come and have a wonderful time!

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