# BRITISH SOCIETY OF CLINICAL AND ACADEMIC HYPNOSIS

## NEWSLETTER

## Sex and Relationships Theme

**Picture: Honeymoon Reflections**

Volume Eight, Number Ten March 2017

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**Editor's Note**

This issue is jam packed with content, so I'll keep my ramblings brief, and let you enter a world of sex and relationships. You will see from the variety of articles that have been included that sex and relationships is a very broad area, and one that we often encounter in our practice without even realising it. If reading has stimulated any further thoughts for you, please do get in touch.

As I write, world sleep day has just passed, and it seems like a good time for us to have a themed issue on sleep. So, tweet me or email me on how you use hypnosis to aid with sleep in your personal, and professional life and we'll have a sleep inducing and aiding next issue. What works for you to aid sleep, and what doesn't?

We currently have a small but effective team of BSCAH newsletter proofreaders. Would you like to join this team, ensuring there are no typos in the final version of the newsletter? If so, please get in touch!

Charlotte Davies, BSCAH Newsletter Editor

## Notes for Members

### BSCAH Mailing list

Many members will be aware that National Office has had problems with sending out group e-mails. This has resulted in us having to set up a mailing list. This entails members having to opt in and confirm that they are happy to be on the list by replying to an invitation sent out by an automated system that does look suspiciously like a spam e-mail. Many have still not responded to the BSCAH mailing list request.
Please keep an eye out for Hilary's e-mail from National Office and maybe check your spam filters if you are not already on the mailing list….

### Would you like to go on the BSCAH Referral list?

Some members with the Diploma were unaware that they could go on the referral list. Entry to the list is available to those with the Diploma or who have Accreditation.
A form has to be completed every three years, and there is a CPD and supervision requirement which is not very onerous. If you are interested please contact National Office.

### Peer Supervision

Are you able to provide some peer supervision on an ad-hoc basis? This is a great opportunity to help another hypnosis practitioner, and maybe learn something yourself! Contact National Office if you can help.

### Diary Dates

There are plenty of events coming up and we've listed them all at the back of the Newsletter. Let the editor know if there are events that should be included next time!

### Next Newsletter

The next newsletter will come out some time in the Summer. We will be focussing on sleep, but as you can see from this newsletter, contributions on any topic are more than welcome. Send your snippets, pictures, event reports, case reports, musings, links, and anything you like to charlotte.davies@doctors.org.uk or tweet to @onelongplait or @BSCAH1.
There's so much out there - we need to build bridges across our islands of knowledge, and help support each other.

**Branch Reports - Lancs. and Cheshire**

We had a departure from the norm for our first meeting of 2017 - branch members joined our foundation trainees for part of Module 3. The rationale for this was to improve the numbers of trainees who go on to become branch members by allowing them to meet and chat with existing members. The topic for the morning was pain and we were pleased to welcome Grahame Smith from Northern Counties as our guest speaker. Grahame gave an excellent lecture beginning with the definitions, components and meanings of pain, followed by covering the types of therapeutic interventions we might use within the sphere of hypnosis. To conclude the presentation Grahame gave a great demonstration of the difference hypnotic intervention made to pain tolerance using the cold pressor test. Trainees were then paired up with experienced branch members for a practical session on the cold pressor test, which seemed to go down well with everyone. We are hoping to coincide branch meetings with foundation training modules again in future, as it seems to be a worthwhile exercise.

In February we had another variation on our usual branch meetings - an interview with Cath Potter. Cath has gone further with hypnosis than anyone else in our branch and, as she retired from clinical practice last year, it seemed timely to explore her experience. We discussed Cath's career and how she became intrigued by hypnosis as a result of meeting the late Alan Kendall. Cath trained with Northern Counties in 1990, going on to take the Sheffield diploma course, followed by a masters and then completing an Open University degree in psychology. Cath told us how she had used hypnosis with her dental patients in the community dental service and general dental service before moving into academia to teach dental students. After two or three years she was offered funding for a PhD, something she described as very difficult and which took her six years to complete. Cath talked about the problems she had encountered during her research project, which compared the effects of hypnosis in reducing anxiety for subjects receiving nitrous oxide sedation to the effects of listening to a story in the control group. In retirement Cath has taken up open water swimming, but intriguingly she doesn't use self-hypnosis to help her with the rigours of this, preferring to rely on an expensive neoprene wet suit! Cath's top tips for our group were 1. don't think hypnosis will cure everything; 2. there will always be failures and 3. never give up.

In March Adrian Hamill gave a presentation entitled "Acceptance Theory - beyond inclusivity" or "Accept yourself for a change". Filthy weather, plus illness and holidays, prevented some regulars from attending, but those branch members who did attend all gave very positive feedback. Adrian talked about Bill O'Hanlon's use of inclusivity and said he has put a different slant on this with acceptance theory. He said that when people have had a problem long term, often it is better to accept the problem rather than fight it and instead focus on what is going well, and by doing more in that direction, producing change in the presenting problem. Inclusivity helps people come to terms with ambivalence regarding their problem. The past cannot be changed, but it can be reframed. Adrian said accepting and validating a person's feelings is important, but that is not giving them permission to act out those feelings. Too much acceptance will not lead to change. Adrian described disclaiming a part of oneself as like holding a beach ball under water - it uses up a lot of energy. Accepting oneself frees up energy, which can be put into what one is good at. Adrian asks people to keep a diary on what went well each day and sets homework. He demonstrated the power of validation and good listening in treating patients and concluded with a very enjoyable ego-strengthening session for the group.

Our next meeting is our branch AGM to be held on 2nd April. Our joint meeting with Northern Counties is a work in progress at the time of writing, but we are hoping to hold the meeting on 23rd June in York. Watch the website for details!

Linda Dunlop
Hon Sec


## Is your therapy gender aware or gender blind?

We all want to do the best for our clients and most people believe in gender equality, but what if I told you that the motivation to see men and women as the same might be limiting your ability as a therapist?

In medicine, recognising sex differences is an important fact of patient care, and of course obstetrics and gynaecology would not exist without this recognition. Even outside sexual medicine, it can be important to recognise sex differences e.g. the symptoms of heart attack are sometimes different in women and men (Lichtman et al, 2015).

In academia today there is a fashionable reluctance to recognize sex differences, exemplified by Hyde's (2005) 'gender similarities hypothesis'. Gender is seen as a product of culture, and the evidence for the contribution of biology to gender (e.g. Hines, 2004) is ignored. So although the average person will acknowledge – or indeed value – everyday gender differences e.g. boys as young as 9 months tend to prefer playing with cars than dolls (Todd et al, 2016), some academics find generalisations about such behaviour threatening to their idea of gender equality.

But I am not trying to win a nature-nurture debate – I think the weight of evidence (e.g. Hines, 2004) demonstrates that gender differences result from a combination of nature and nurture. The point is that taking a 'gender blind' approach is a highly questionable way to maximize the health and wellbeing of men and women.

I began investigating gender differences after pondering why men commit suicide at 3.5 times the rate that women do (ONS, 2015), yet seek psychological help far less than women do (Kung et al, 2003). It almost seems that some men would rather kill themselves than talk to a therapist. But rather than blaming men for not being man enough to talk about their feelings – that is hardly a client-centred approach - I think we need to find out how therapy can be made more appealing to men. In taking the latter approach, myself and colleagues interviewed 20 life coaches (Russ et al, 2015), 6 hypnotherapists (Lemkey et al, 2016), and 20 psychologists (Holloway et al, in peer review). We found:

- Almost all of the therapists we spoke to identified sex differences in some aspect of therapy
- Regarding therapy, in general women want to talk about their feelings and men want a quick solution to their problem.

- Most therapists – though none of the hypnotherapists – showed signs of struggling with cognitive dissonance when asked to talk about gender differences in the needs of their clients.

This third point highlights what is an important psychological barrier against making best use of the insights of the first two points. Although hypnotherapists – at least in the small sample we spoke to – can take some pride in not suffering from gender blindness in their therapy, other psychological therapists need to catch up. To this end my colleagues and I put on free lectures, free films, and an international conference aimed at raising awareness of these issues. More importantly, there is a vote amongst members of the British Psychological Society (BPS) in April (details in footnote) when we will decide whether we want to have a specific section of the BPS dedicated to addressing issues such as male suicide, help seeking, male-friendly therapy, and other issues.

In my experience, more and more psychologists are catching up with what many of us already know: men and women are largely similar, but it's the differences that often make all the difference. This means that therapists who use a gender-sensitive approach to therapy are likely to be delivering a better service.

Members of the BPS can vote for the formation of the Male Psychology Section in early April. The April edition of The Psychologist periodical will include a ballot paper which you can mark X and return to the BPS in the prepaid envelope. Note that any previous online votes for the Section don't count – you will need to return the postal ballot paper in order for the new Section to be created.

John Barry

References available from the editor, or BSCAH website.

## Pathway Project

As a GP I practised separately in sexual health, under the guidance of Judith Dewsbury who was a consultant in sexual health here in the Midlands. She is greatly missed, and nobody has filled her shoes. But in recent years the focus has changed to work with the survivors of sexual and domestic abuse in the Pathway Project, based here in Lichfield. I run life coaching courses for survivors - those who have come through the refuges and in the process of putting life back together for themselves and their children. The situations they are coming out of are almost unbelievable. Our hypnotic techniques and time-line work are key ingredients in their rehab - with a lot of acceptance, congruence and positive regard!

Trevor Hadfield

## Working with Abused Clients

Hi, I'm Sara, counselling psychologist, Clinical Hypnotist and Creative Therapist BACP Reg, BSCAH. I run my private practise from my home in Barlaston, which is located a few miles away from Stoke on Trent in the County of Staffordshire. Its often described as a Midsomer Village, and is an ideal location for using nature to help my clients.

Let me to introduce you to my working day with abused clients. By the time a client has arrived at my front door they have driven through the countryside, parked their car or walked to my long driveway and in walking up the drive to the front door have heard the birds singing and subconsciously or consciously taken in the colours, scents and sounds of the garden. The heightened emotion of coming to see a 'counsellor' has put them into a lovely altered state (lovely for me that is), often this means on opening the door I am faced with client who is ready for action and if it is hypnotherapy they have made an appointment for we are half way there already. That's my professional take on it anyway, from their perspective obviously the painting may not be coloured in that way at all, the stress of getting to the appointment with a dreaded 'counsellor' what the hell is she going to be like, the traffic on the main roads, having to drive through windy country lanes and getting stuck behind a tractor 'oh my God how slow do THEY drive' finding the house and 'is that it, oh her name plate is by the door....that's it... do I knock on the door or ring the bell, decisions decisions ...someone's coming (heart beating... head pounding...)....oh it's her... she's smiling, ' smile nervously and go in.

For people with a strong olfactory emotional response it's really important to find a safe smell for them to work in. Disinfectant and floor cleaner have triggered stressful reactions from clients on entering the hallway where the floor tiles are mopped, increasing their anxiety. I have had to change the floor cleaner to a 'cotton fresh' smell which I find is more soothing generally for clients, it is kinder for new clients and eases them gently into the environment.

I have found as I have gained experience over the years (about 20 now) that it is quicker to pick up the clues from clients, the information the person is unwittingly giving away all the time (as I am now to you as I write trustingly, honestly, and freely of my experience with hypnotherapy). As my process of understanding the client has speeded up so has the time needed to work with

clients to meet their aim, hypnosis also helps facilitate a shorter counselling process.

Let us continue the journey...on the walls in my home I have positive affirmations leading to my counselling rooms (2 rooms one for creative therapy one for more traditional therapy) and pieces of artwork to provoke contemplation and both conscious and unconscious awarenesses. I have a variety of textures along the way, bowls of shells, stones, jars of colourful buttons on the window sill, etc etc, (what is she whittering about you may be thinking?)... maybe you are, maybe you are not. I find it incredibly useful to note the person's reactions as they walk through this metaphor rich environment, what are they drawn to, how do they connect, their body language, their breathing patterns, what soothes, intrigues, humours or alarms them! And noowwww.... we arrive at the therapy room and enter as safe, warm and comfortable an environment as I can create for each and every client we also arrive at the point of this article. I reflected on this issue of the Newsletter and of my experience within private practise and hypnotherapy with my clients regarding sexual matters. I use a sensory rich environment in which to enhance my clients emotional engagement, whatever the aim. I have learned to recognise the shadow of sexual abuse and its many echoing patterns around a person's life. The trauma shadow which presents following a rape (maybe decades ago), the shock of abuse, the emotional or physical bruises which accompany the client as we sit together or walk together, or paint or sew or make pottery as they share their stories, their experiences, in as non threatening environment as I can provide. It is often the case, in my experience, that a sexually abused client will present with a non sexually abused 'problem', they come with overeating, alcoholism, smoking, relationship issues, anger management, to name but a few, and underneath these 'symptoms' may lie a root cause of abuse. Its not often that they walk in, sit down and say outright 'I'm here because I've been sexually abused'. Often they come with a nuisance trigger, as hypnotists we know them as anchors which are unconsciously created all the time - negative anchors when created in abusive situations ie. rape or abuse of any kind, can be troublesome and escalate if the person does not seek help. Sometimes it can take people years, decades to notice their patterns and realise it has come from an abusive situation, sometimes the memory is so well hidden from themselves that when it is revealed by themselves to themselves

it can be life threatening literally the point of suicide. The sexually abused client may present with alcoholism, overeating, agoraphobia, any phobia at all, so it takes time to uncover the root of the problem unless that person is well aware of the issue and comes right out with it and says 'I'm here because I've been abused...'. and that doesn't happen very often. Whatever the client has come with my aim is to provide a soothing, non threatening, empathic environment in which the client can become stronger and empowered to move forward in their lives along their chosen path. You never know what colour, shape, sound, texture, etc is going to provoke a flashback, trigger an emotional meltdown. To help identify these I often use a sensory inventory (either verbally or via a form) to find out where some of these anchors lie. This information is often useful to me, calming anchors are, really helpful with abreactions, to enhance safe place, to facilitate a client to calm down. Helping the client to recognise their anchors and using safe place technique teach them to create their own safe environment can be hugely empowering to them, it can be a life changer. A few years ago, having taught this to a particularly at risk client with a freeze response (a very dangerous response when someone actively wants to kill you) she was subsequently in a life threatening situation but was able to maintain her composure and get herself and her child into a room locking all doors behind her and barricading the door. By the time the police arrived they reported she was in a world of her own under the bed with her child chatting about their safe place. Still alive!! Now I call that a real result. Empowering stuff this hypnosis. With a relaxing script, to facilitate the client to build their safe place in their own mind many positives are created and developed, facilitating positive self esteem, boosting inner strength, by the use of ego strengthening and perhaps the most important of all soothing. Self soothing is often something the sexually abused client is unable to do. By suggesting the ideas covertly in conversation or directly in trance state I am able to help teach the client this very important skill.

For clients with troublesome daily triggers which take them to a frightening place I have found the zip technique is a quick and easy way to change the trigger, whatever it may be, into nothing of any importance. The client who could not stand the sound of someone chewing food as it reminded them of their childhood abuser was able to eat happily alongside their loving partner who reportedly ate with great gusto very noisily. This took much stress out of their

relationship. A quick intervention but a long lasting result. I have found it very useful to remove a number of negative triggers such as this from a victims daily life. The most useful intervention I have found with rape victims, whether the rape is recent or decades ago, is the REWIND technique. Its ability to transform a traumatic memory into a memory with the trauma is outstanding. Often the client will recount their story of abuse and the fact that I bear witness to that story in itself can be very healing for them, where clients are unable to verbalise (or create the story using art materials/ metaphor) this technique is hugely beneficial - the heightened state a client needs is not difficult to attain in these cases and is often there on arrival at my door. In cases where abused clients report flashbacks and trauma which impacts on their daily life I would highly recommend the Rewind Technique.

I am extremely glad to have these techniques in my toolbox, the ability to soothe, reassure, calm, strengthen and reframe in quite a short timeframe is helpful to both my clients and to myself. After a particularly stressful session where the sexually abused client has filled the room with trauma and troubles, toxins and poisons, that may have been bottled up for many a while, it can feel like a gift to end the session with a safe place script. A gift not only to my clients but to myself as a great way to put away work at the end of the day. Walking the client out of the room, along the tiled hallway, and then closing the door behind them, then taking a few minutes to breathe and be safe and let the work stuff drift away, allowing myself to let go of the grief, the toxins, pain and hurt that has hung around me during the day, by taking just a couple of minutes to visualise and breathe it helps me to let... it... go.... allows me to reconnect quite easily into my family life, and that feels good.

Signing off here, don't forget to breathe easy! Warm regards,

Sara Llewellyn

Throughout these pages, there’s a few screenshots of some “tweets”. Twitter is a website where people can disseminate information, with a character limit. @BSCAH1 tweets. Some tweets tell you what is happening now, some what is happening later. Some tell you about research or opinion. Some ask a question. It can be a useful way of finding extra information. Do you use Twitter?

## Let's talk about sex…

Don't let pain stop your sex life

First the good news: there is considerable evidence that a satisfying sexual experience in people suffering with chronic pain can result in several hours of pain free time afterwards.

Then the not so good news (it's not as bad as it sounds so bear with me here). Whereas before you had your pain your sex life seemed spontaneous, now it is different. Unromantic as it seems, it is possible to have a great sex life even if you suffer from chronic pain but it might take a bit of planning and a willingness to break old habits. You may be familiar with the idea of planning, and organisation can be a key to taking back control and it's true in the area of your sex life as well. It's all in the timing.

It may have been usual for you to get intimate with your partner at bedtime. But in the new world this might not be the best for you. We often experience pain at its worse when we are tired – so late night sex might mean you are choosing the very worst time. Best thing is to track your own pain, you will almost certainly find that the pain worsens and lessens in a regular pattern. So, for example you might be most pain free in the morning, or after lunch. If this is so then see if you can make this your chosen time for sex if you can.

*Silk sheets*

Love and cherish your bed. Make sure it is as comfortable as possible. Some people swear by silk sheets, the ease of movement they allow can be wonderful. Also keep warm, an electric blanket to make the bed cosy might be a good idea. Remember that good sex starts in the head. Cultivate a positive attitude and build up your self-esteem. Also remember you have nothing to fear. The longer you avoid sex the more difficult it will be to re-start. So just get on with it – don't worry too much if it isn't perfect, it can still be fun and satisfying.

*Check your medication*

If things do not seem to be working out it is worth checking your pain medication. Some common drugs for pain inhibit libido and affect blood flow and hormones. Often by adjusting the dosage or changing the medication this problem can be overcome. So see your GP.

*Find out what is right for you*

Don't be afraid to do some research. And get creative. Google 'sexual positions for (your type of pain)' there may be ways to be intimate which you haven't thought of.

There will be times when you feel in too much pain to want to have sex. Talking, cuddling up, laughing together just being with the one you love has a sweetness of its own. So don't be too goal orientated. It's not a competition.

*Good websites*

Many of the best websites are based around particular sorts of pain, so here are a few which may cover what you need.

www.ic-network.com/patient-resources/romance-intimacy/

www.guts4life.com/living-with-ibd/ibd-and-you/intimacy

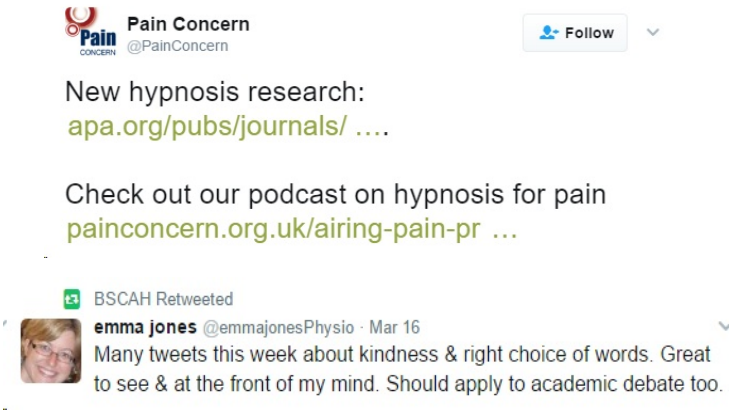
www.arthritisresearchuk.org/arthritis-information/arthritis-and-daily-life/sex-and-arthritis.aspx

www.spine-health.com/conditions/lower-back-pain/back-pain-and-sex

http://www.everydayhealth.com/hip-pain/hip-pain-and-sex.aspx

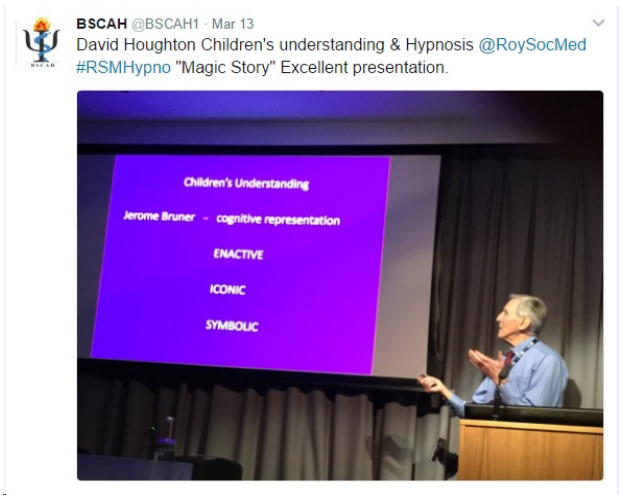
http://www.mayoclinic.org/chronic-pain/art-20044369?pg=1

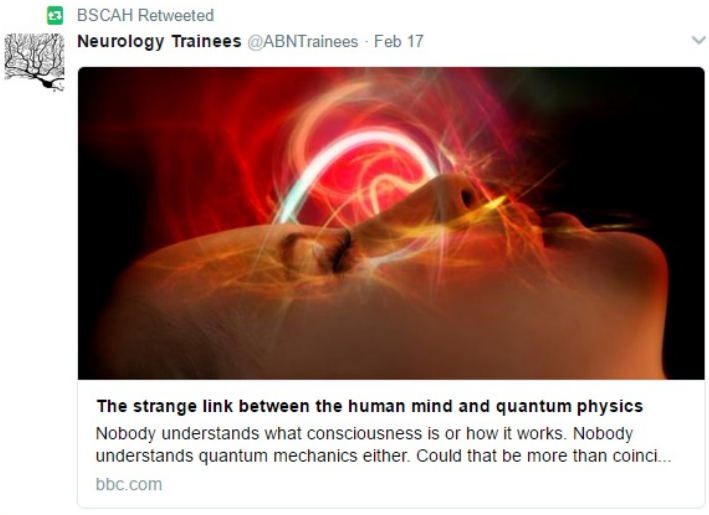
Sue Peacock







## Case Study: "A Lightbulb Moment"

"Stephanie" had come to me with general issues around confidence. She had had an acrimonious divorce from a man who seemed to have been undermining her confidence for some time in the course of their relationship, criticising her skills as a mother and generally putting her down. "He's horrible, he makes me question me". [NB., this is an interesting turn of phrase, which sort of implies a dissociative tendency to judge herself, as if from a different standpoint, something that I made a mental note to exploit in a therapeutic way]. She had told me that they had two daughters, aged 18 and 13 respectively, who lived with her, so occasionally she had to have contact with him in the wake of their divorce. She told me that she had always had issues with confidence and assertiveness. "I hate confrontation" "I offload onto other people" instead of the person that she needed to approach in a conflict. At some point during this session, she mentioned moments of enlightenment, when she felt she had achieved some momentary insight: this was to occur to me later on in the induction, as documented below. The following brief account is of the third session I had with her, after our initial assessment, risk assessment and establishment of her "safe place".

I started by giving her a "pep talk" with a battery of embedded suggestions (examples italicised), encouraging that she had the inner resources to achieve and to find solutions to be able to improve the way she was able to deal with the everyday situations that in the past she had found difficult but could be surprised that every day she could etc. etc.

The best results, I have had in my limited experience using clinical hypnosis, is to utilise a deliberately vague and non-directive approach, on the basis that the unconscious mind is often able to find solutions that neither the client nor myself can find. My standpoint is that the safety and wellbeing of myself and the client is of paramount importance, and I plan for all contingencies, particularly the possibility of a spontaneous abreaction, which so far I have not had happen, and I screen clients for any dislikes, fears, traumas etc., as part of my risk assessment, and avoid using any imagery that may remind someone of unpleasant memories. Conversely, I can sometimes weave anything pleasant (to the client) into an induction.

I knew that Stephanie was due to go on holiday in a few weeks, and we had spent a bit of time, under the guise of polite conversation talking about it, and how she was looking forward to it. I had decided to use a variation on the "4 seasons induction" in which the therapist takes the client on a guided journey through the seasons and back again. I used a similar approach, but using a day, starting on a sunny morning, looking forward to the day ahead, setting off on a leisurely walk , along a beach through to midday, maybe having a paddle, to a lane dappled with sunlight through the trees in the afternoon, to evening, watching the stars. And maybe pausing for a few moments to wonder at the stars, and to perhaps focus on one star, just for a few moments…I avoided any detailed description, allowing Stephanie to "fill in the gaps". It seemed appropriate to suggest that as she comes in from the night that maybe she could be at her accommodation in the resort, and spend some time looking around, using overlapping senses. And in this place, I wondered whether she could walk around, be in control of her environment, maybe adjusting the lighting, because she could switch the lights on, dim them, or switch them on or off, whatever would be appropriate. [This was intended to resonate with her, so that maybe she could have more "lightbulb" moments]. And then I suggested that maybe she could relax, in her holiday accommodation, and doze off after such a pleasant, but tiring day. And whilst she nodded off to sleep [a trance within a trance], I told her that I would start to talk to her unconscious mind, and all she had to do was to relax. I don't like using scripts normally, but anecdotally, from speaking with BSCAH colleagues, Hartland's Ego Strengthening Script is a useful approach for clients with self esteem, assertiveness and confidence issues. I do tend to adjust the language somewhat so it has more of a permissive, rather than an authoritarian tone to it. On awaking, refreshed and ready for the day ahead, I guided her yet again from night, to afternoon, to midday, to morning. This peculiar "Alice through The Looking Glass" world of going back through a journey helps to arouse curiosity, and can be quite simply fun. Also, from a therapeutic standpoint, it (theoretically) helps to promote post hypnotic amnesia for the therapy (vis. the ego strengthening) so that the conscious, critical mind cannot analyse, dismantle and possibly sabotage any positive suggestions.

A good level of trance had been reached, mainly evidenced by the big smile and stretch as she brought herself out of trance. It is often gratifying for the client

to have had a good response. The next time I saw her, it seemed that there had been some positive change in her presentation, specifically that:

* She felt more resilient to dismiss her ex husband's criticisms and put downs.

* She had been able to deal assertively with a situation with her present partner.

* She had been able to say "no" to a request to baby sit from a friend, who she had felt unable to refuse on previous occasions.

* She had not had any "meltdowns"

* She was feeling generally more positive and optimistic.

Jim Moorhouse RMN

BSCAH member West Midlands.

References available on the website, or from the editor.

**Disclosures**


A guest post on First10EM covers how to acknowledge disclosures of child abuse from children. It focusses on the language you could use, and has a link to the author's thesis at the end.

https://first10em.com/2017/01/23/at-a-loss-for-words-communicating-with-children-after-child-abuse/

**Resources**

The Lucy Faithfull foundation works to reduce the risk of children being sexually abused. Through their website, http://www.lucyfaithfull.org.uk/, patients, professionals, friends and family can anonymously access advice on how to stop children being abused. This includes downloading and viewing images. . http://www.stopitnow.org.uk/ has lots of useful resources and if you work with sex offenders, make sure you read their tips for self care.

In my experience this can normally be treated very quickly, assuming that physical (including pharmacological) causes have been eliminated. Non-medical practitioners should of course always ensure that the client has first consulted their GP. Presence of early morning erection emerging from REM sleep indicates physiological function is unimpaired, therefore a very positive approach can safely be taken, creating positive expectations of rapid return to normal performance.

I do not spend much time in analysing the possible causes of the original loss of confidence. I emphasise that this is a very common problem, typically originating with an episode of tiredness, illness, or temporary loss of confidence for whatever reason (I've known some clients to have previously had up to eight sessions of "analysis" with a different practitioner, without any improvement in their symptoms).

In my pre-trance discussion I emphasise that sex is an automatic process. Typically I use the analogy of an autopilot or thermostat. I point out that the client does not need to do anything to increase his heartbeat when running, nor to switch on the flow of gastric juices when eating- "your body takes care of this for you, automatically with no conscious thought being needed." Many other examples can be given, to demonstrate that the vast majority of the client's physical activities are actually controlled automatically, in many cases even by spinal reflexes.

I next introduce the idea of both partners' responses being mostly "automated," as in "her body responding to your body, and your body responding to her body," with as much or as little detail as feels appropriate. The therapist should not to feel compelled to use any terminology that he or she would find embarrassing to say aloud, as this could create a sense of tension which the client could pick up on.

In the trance itself I start by going for the deepest achievable subjective level, aiming to enable the client to experience a state of mind markedly different from ordinary consciousness. Inducing catalepsy by means of the Ellman Induction is one of the simplest methods. To deepen trance I avoid imaginative visualisations, as many clients are not naturally good visualisers. I prefer

guiding them through imagined tactile experience, e.g. walking along a beach and feeling the different textures of the sand, the sunshine, the sea breeze, etc. This will in fact often induce spontaneous visual imagery even in clients who have previously thought themselves unable to visualise. Alternatively I may draw the client's attention to the abstract colours that appear "behind your closed eyelids" ie the entoptic imagery produced by the optic nerve. Many clients spontaneously elaborate these colours into kaleidoscopic patterns into which they feel themselves drawn deeper.

As regards the actual therapeutic suggestions, once the client is profoundly relaxed, I link this experience to the memory of profound post-coital relaxation, satisfied and replete. I then lead the client backwards in time through the period leading up to this experience, ie successful sexual activity preceded by foreplay. I speak only in very general terms, letting the client fill in the details (firstly to avoid embarrassment, secondly because I don't know the client's sexual tastes, thirdly to avoid unnecessary sense of intrusion into the client's privacy). Throughout this stage I continually emphasise the idea of the client's body responding automatically to his partner's body and vice versa, encouraging client to focus on his partner's body not his own.

I then guide the client fast forward through the whole experience. Time permitting I might go back and forwards a few more times. This is an adaptation of the well-known "Rewind" technique for reducing anxiety.

Finally after terminating the trance I change the subject of conversation, ideally picking up on anything unrelated to the problem that the client was talking about previously. This is done deliberately to encourage conscious amnesia for the content of suggestions given in trance, thus reducing the possibility of the conscious mind "picking apart" the suggestions. The idea is to create a "seamless" continuity between pre-trance and post-trance experience, thus "walling off" the content of the trance experience.

At the end of session I ask the client to report back to me in one week's time, emphasising that in my experience one session is normally enough.

Peter Luce

## Notes on Society's RA&D Strategy

*What is RA&D?*

'RA&D' stands for Research, Audit and Development. They are usually considered as either 'Audit and Research' or 'Research and Development'. For the purposes of this article they will all be considered together.

*Research* is the formal process of finding out new knowledge, and usually that is knowledge in the context that no one has previously known. Occasionally it may refer to someone uncovering previously known knowledge that has since been forgotten, or abandoned. In the context of clinical practice, be it hypnosis or otherwise, research is often aimed at finding out what is best practice, i.e. what is the best thing to do given a specific set of circumstances?

*Audit* is the formal process by which the question is being asked, "Am I undertaking best practice?" "Am I doing the best I can be?" The audit question takes the knowledge arising from the research that forms the evidence base research and sets a standard to be achieved. The standard may be 100% if it is something that should be done every time. The standard can be less. so if the research base states that only 50% of patients improve with a particular, therapy, the standard may be 50%. The standard can be set for an individual patient on an individual basis, or as a collective. So for example Assen Aladdin's work demonstrated that he can achieve better results using hypnosis, cognitive therapy and mindfulness together than any one alone. Thus the standard may be set that a therapist will offer all 3 therapies to the relevant patient every time, but as a group set the standard that only 80% of patients will improve. Another standard may be simply to demonstrate that the one patient is better.

Audits can be based on structure, process or outcome. In running a hypnosis service, a structural audit, may be will look at buildings, the numbers of therapists available, the consulting room, the risk of interruptions etc. A process audit, will look at how the referrals are made, are there separate assessment and clinic sessions, and follow up arrangements. Outcome audits will be testing if patients are better or satisfied with their therapy. This may be achieved through an objective count in the reduction in symptoms, psychometric testing or patient satisfaction questionnaires.

Development is applying the research findings and putting them into practice. Development often implies putting into practice a new service or an additional capability to an existing service. Development often has a pilot, a small scale of the full programme to address viability and feasibility, before the decision to provide the full roll out. But a pilot may also be used, to deal with issues arising on a smaller scale thus knowing what to anticipate and thus pre-empt difficulties before they arise on the full development.

There is considerable overlap between each. All three, research, development and audit are driven by data collection. Asking the right question for each gives the guide to the nature of the data to be collected.

But understanding the difference between each is important because of their different requirements. Audit needs no prior approval and can, or possibly should, be undertaken by anyone providing a service. Research, and essentially if involving patients may require ethical committee approval. The rationale can simply be put as there is a known best treatment which should be the treatment of choice. Introducing a new therapy/treatment may make the patient worse, or interfere with the standard approach and therefore the research proposal needs to be independently reviewed prior to ensure that the patient's safety and well-being is maintained. Without such prior approval, publication of any results may be in jeopardy.

Population surveys sit somewhere between audit and research. Without a standard they cannot be called audit. But it also needs to be clear whether doing a survey adds useful knowledge.

*Development*, depending on where and how may also need prior approval. This will certainly be true for developments within the NHS. In today's world of austerity, as well as demonstrating efficacy, a new service must also be able to argue there will be financial savings and that the pilot has materialised those savings, so that the wider programme may be propagated. This may not always be that easy. Service development also is a form of research. If there is a genuine innovation, the experience of that innovation, will not have previously been recorded and therefore there is some requirement to give an account describing the implication.

## Why the need for a strategy?

BSCAH was born out of the merger of the two original societies British Society of Medical and Dental Hypnosis (BSMDH) and the British Society of Clinical and Experimental Hypnosis (BSECH). The latter society particularly had a culture of scientific research into the neuroscience of consciousness and hypnosis. Since the merger the scientific base that was present in the original BSECH appears to have diminished. While the Society's clinical and educational roles, both to the trained hypnotherapists and the clinicians interested in hypnosis, are progressing well the more strictly academic and research aspect has waned. This needs to be put right, not because it is part of the parentage of our Society but because the message of the benefits of hypnosis is not getting through to where it is most needed.

The Society's memoranda, amongst other things state the following:

- To promote for the benefit of the public the study, teaching and use of hypnosis in the fields of medicine, dentistry and psychology.
- To promote co-operation between the disciplines concerned and to provide and extend the knowledge and understanding of hypnosis.
- To stimulate research and encourage scientific publication in the field of hypnosis.
- To promote the acceptance of hypnosis as a valuable and legitimate technique of scientific enquiry and practical applications.
- To support measures to protect the public from the exploitation of hypnosis for the purposes of entertainment, and for alleged purposes of therapy at the hands of inadequately trained people.
- To co-operate with learned and professional societies in Britain and abroad that share relevant aims ethics and interests.
- Generally to engage in activities relevant to the study, teaching and practice of hypnosis and maintenance of high standards of practical applications therein.

Members of the Society all share in a passion for hypnosis, but we are also fully aware that its place within clinical practice is very limited. We know the role and benefits of hypnosis to patients and we all feel that society and therapeutic practice as a whole is missing out by hypnosis being so scarcely available.

While we in BSCAH may be doing some of the above, and in particular over the last 2 years we have been more active in bringing hypnosis to the minds of clinicians, its use has as yet not made major in-roads into clinical practice.

The reasons are very clear cut.

1. Austerity, value for money and evidence base medicine demands that only proven therapies for specified conditions may be commissioned.

2. Commissions such as the National Institute for Health and Care Excellence (NICE) set the parameters and recommendations for health service commissioners and clinicians to follow. In so doing, NICE sets the agenda.

3. The profile of hypnosis is not high. It is not that the evidence is lacking, there has been substantial research but it is overwhelmed by the quantity of research on CBT and other psychotherapies.

4. The numbers of experienced researchers in the hypnosis field is very limited. Thus many of the papers while showing the benefits of a hypnotherapeutic approach, fail to reach the rigour of Cochrane or of a properly studied meta-analysis.

5. Research demonstrating the efficacy can be superseded in time as newer therapies arrive that are more efficacious. In order for research papers to achieve recognition, they need to take the known best practice and hypnosis needs to be compared to this.

6. Although it alone may confer benefits, hypnosis is less a therapy and more a modality for providing the therapeutic intervention. It would be akin to stating that the patient with an orthopaedic or gastro-intestinal problem was treated by anaesthesia, without stating the surgical intervention.

7. Psychotherapies are best provided when tailored to the individual patient. Quantitative research is best achieved by randomising individuals and delivering the therapy in a consistent and uniform fashion. The efficacy of personalised therapy is much harder to demonstrate to a skeptical 3rd party, even though it may be very obvious to the patient and therapist alike. The kind of therapy that hypnosis is, does not lend itself naturally to the two markers of good scientific research, namely ‘reproducibility’ and ‘predictability’.

8. Other therapies have metrics that are able to measure the amount of the particular therapy that was provided to the client. Hypnosis does not.

9. This would never be admitted by academic quantitative researchers and scientists but there does appear to be a prejudice against the use of hypnosis. The prejudice comes from the fact that it is seen as a complimentary/alternative therapy; with minimal training a person can set themselves up and call themselves a hypnotherapist; and it has an image as portrayed by stage hypnosis.

All these factors create frustration in our members and others who feel stymied by the current climate. As a society we need to be helping and supporting those of our members who wish to undertake audit and research; and also those who wish to convince others for its efficacy and hence provide a hypnosis service.

The skills required to be a good researcher and a good clinician are very different. It of course does not mean that a person cannot be both, but there is a different type of thinking. The skills and abilities required based on the steps of the process are listed in the Appendix.

Audit is the easiest to undertake, because it is something a clinician can learn with a little education and guidance. Audit ought to be something that all clinicians do.

But engaging in the production of good research or in the development of a service using other people's money without training, supervision and experience is not easy. There is an expected rigour that needs to be sufficient to convince the skeptical that one's own results are transferable to other situations and populations. Good researchers, like good clinicians develop through training grades.

As a Society, while our resources may be limited, particularly human resources, if they can be focussed onto certain priorities there will be the efficiency of direction.

**The Aims of the strategy**

Taking all of the above together the aims of the strategy need to be:

- To be active in research, audit and development (RA&D).
- To develop the RA&D skills within the Society

- To be supportive of clinical and scientific research.
- To be supportive of members and non-members who wish to undertake hypnotic research.
- To have tools and expertise available to support members at the various stages of RA&D.
- To have its own research project.
- To support and encourage those research projects that may advance the use of hypnosis in general clinical practice.
- To promote the research evidence available.
- To promote a more individualised research paradigm.

**Resources to the strategy**

- Website

The BSCAH website has a lot of useful information on hypnosis, the conditions it treats and some of the evidence supporting. There is scope for expansion to have readily available tools.

- Human

BSCAH has a small membership. Thus the workload falls onto a few. Nevertheless we know there are those who are experienced in research, though may not be in the clinical hypnosis research that is required to bring it to the fore of the minds of clinicians,

- Funds

BSCAH has a small amount of money left through a legacy. This money may be able to support certain projects but its use would need to be judicial.

**Actions to support the strategy**

The strategy is to have 3 phases. The first phase is the quick wins, those matters that can be achieved now. The 2nd phase which can be started in preparation is a survey of members, and the third phase is starting to deliver on the outcomes of the survey.

*Quick wins*

There are certain tasks that could be done immediately that would make RA&D more amenable to members. These should be put in place as soon as is feasible. These include:

- Having the evidence for the efficacy of hypnosis for each of the major conditions in a readily available format. We need evidence for weaknesses of research undertaken, legitimate areas of further enquiry, cost - effectiveness.
- Templates should be available for writing an audit proposal, audit, ethics approval, funding grant application, research proposal, patient explanation leaflet, research consent form, running a clinical hypnosis service and writing a patient video consent form.

**A survey**

It is now six years since there has been a survey of members. Another would be timely. The focus clearly needs to be on the Society's AR&D status. Suggested areas to ascertain:

- level of skill in AR&D
- Previous experience, Successful outcomes and not so successful outcomes.
- personal hopes and aspirations
- Ideas for the Society
- What help they can offer to others
- Articles they could write

**Longer term plans based on survey results.**

These would need to emerge from the survey but ideas already suggested by members include:

- The use of readily available technologies such as mobile phone sleep apps
- A BSCAH research network
- Making contact with the private sector who may be interested to support research.
- Can data amongst members be standardized?
- Increasing the qualitative research skill by for example, demonstrating changes in the patient experience.
- Focussing research on clinicians and colleagues rather than on patients as these may be easier to achieve. For example is there an untapped resource of therapists who want to do hypnosis but are unable to.
- Drawing upon the skills and experience of the semi-retired
- Encouraging hospital doctors to meet with the Trust's Director of Research

- Having a national audit topic

**More ambitious ideas may include.**

- A research buddy system
- Appointing a BSCAH research Fellow
- Developing BSCAH's own research project
- Developing a research component onto the BCU Diploma course
- Developing a 2nd Diploma course
- Developing a PhD course in clinical hypnosis.

In conclusion we should be aiming to make audit, research and development of hypnosis as one of the core activities of the Society, aiming to promote and develop the skills to as many as want, both inside and outside the Society.

## Upcoming Hypnosis Events

*British Psychological Society Workshops - 5th May*
https://www.bps.org.uk/events/conferences/dop-annual-conference/cpd-workshops

*British Pain Society*
3rd - 5th May 2017 - Hypnosis and Pain session
https://www.britishpainsociety.org/2017-asm-birmingham/

*Royal Society of Medicine*
Public outreach meeting: Patient's perspective
Monday 8th May 2017
The evening event aims to introduce a variety of clinical narratives where Hypnosis has been included in the treatment regime or setting.
Meeting link: http://www.rsm.ac.uk/events/hyh03

*Lancs and Cheshire and York Branches*
Meeting 23rd June TBC

*ESH* - 23rd - 26th August
*AAGBI Workshops* - 5th February 2018

## Diploma/BSc Conversion Course in Clinical Hypnosis and Related Techniques

This award is based upon an existing well established and subscribed course offered to Doctors, Dentists, Psychologists, Dental Nurses, Registered Nurses, Midwives and other healthcare professionals registered with the HCPC, where the provision of hypnosis could become or is part of their professional role. The award will be delivered by accredited members of the Midlands Branch of BSCAH, using their own in-house learning materials and resources. This will be the 61st year in which the Midlands Branch has successfully run courses in hypnosis.

The purpose of this award is to develop the student's knowledge and understanding of the theory and practice of hypnosis within their individual health field, particularly those working with anxious or stressed patients or clients whether in a medical, dental or health/social context. The course will also allow students to learn to manage their own stress levels when interacting with both patients/clients and colleagues together with goal setting techniques while developing interpersonal communication skills.

The award comprises 3 modules and is delivered over 8 face to face contact days at BCU (4 Fri/Sats) over the period of an academic year, with the remainder being self-directed study, enabling students to work at an individual pace. The modules will be a mixture of theory, practical sessions and discussion. Students will enrol with BCU, receive learning materials in the form of module handbooks, and have access to the University Library and online facilities to guide them through the award. They will have also access to the course tutors and a BCU award leader who will provide additional support via e-mail and\or telephone for assignments. Successful completion of a reflective diary, 3 written assignments, and a viva will form the basis of the award.

The content of the three modules will cover both basic theory and practice of hypnosis and stress management with emphasis on theoretical underpinnings and targeting those areas where hypnotic approaches can be useful; such as anxiety and pain. The coursework will also focus on the principles and practice of stress and anxiety management for both practitioners and patients. As the course progresses more advanced techniques for specific problems will be explored and taught. Please see BSCAH's website for further details.

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