**Hypnosis and imagery in the treatment of chronic pain** (prepublication article)

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This article will explore how brief psychological approaches using hypnosis and imagery can be used with patients with chronic pain, predominantly in a Primary Care setting, although much that is discussed here could be applied in the Secondary sector. Chronic pain is defined as pain which endures for more than six months and may last for months or years. It serves no physiological purpose and persists after the time that ‘normal’ healing would be supposed to have taken place. Chronic pain may also range from that of cancer or arthritis, to that which seems to have no single or obvious physical causation. Teaching self-hypnosis and use of imagery can give these patients tools that they can use to help themselves, not only with pain, but also with the emotional distress that so often accompanies and exacerbates it. Unlike medication, self-hypnosis has only positive side effects and can give back some measure of control to patients who feel helpless and hopeless.

**General considerations**

All illness is psychosomatic in that we are mind/body organisms and we have physical correlates with emotion and emotional responses to physical problems. If actual physical damage or dysfunction cannot be determined then all too often the patient feels that the health professionals involved with them devalue their symptoms as it is ‘all in the mind’ and therefore imaginary. Even with our more recent understanding of the pain neuromatrix the view that a pain driven by emotional difficulties is less ‘real’ than that caused by physical damage is still often held, even by health professionals. The pain neuromatrix model proposes that pain is multidimensional and this produces a neural network or pattern of nerve impulses that generates the ‘feeling’ of pain rather than the experience of pain just resulting from sensory output from injury or inflammation. This pattern is affected by our genetic makeup, our experiences, our emotional state and our focus of attention. These neural networks, which give us the experience of pain, can also be activated independently, without any external noxious stimulus or injury, such as in patients with phantom limb pain (Melzack 2001, Derbyshire 2000).

Acute pain may serve a purpose in that it alerts us to physical damage or pathology that may need attention. It is often accompanied by varying degrees of anxiety and shock depending on the context. Chronic pain no longer serves as a message of acute damage, but may serve other, more psychological purposes (see later in this article), and is often associated with emotional distress, low mood or depression (Dominick et al 2012). Exploring the psychological underpinnings of the pain may be viewed by the Primary Care Physician as something for the psychologists (Salmon et al 2007), rather than the busy health professional, mainly because of time constraints; it is often viewed as much easier, if less satisfying, to reach for the prescription pad. However pain and accompanying distress is often amenable to non-pharmacological interventions.

Patients with chronic pain may feel defined by their pain; it becomes their identity, who they ‘are’. Their entire focus may be very negative, focusing on what they cannot do. They may feel that there is no hope of life improving and so depression is common as a co-morbidity (Finan et al 2013, Surah et al 2014). Chronic pain may have had an initiating injury or pathology that is no longer active and in these cases, and in those where there is no visible physical cause of the pain, the patient may feel that those around them think the pain is ‘psychological’ and therefore not ‘real’. Equally, people often find uncertainty and a lack of a firm physical diagnosis intolerable and will clutch at anything that will give their pain a label and therefore validity in people’s eyes. It may not be possible to completely ease pain, such as that from a persisting chronic condition, but much can be done to help the patient manage their pain and live a life that is rewarding and not defined by their pain (Andrew et al 2014).

***Rapport***

In any consultation, building rapport with the patient has got to be the first step, as without rapport there can be no meaningful consultation (Frank 1971; Drisko 2004; Leach 2005). Pacing, or being in step with, the patient’s body language with such simple steps as matching or mirroring body position can have a surprisingly positive effect on a patient encounter (Trout & Rosenfield 1980).

Listening to the patient’s words and matching response to be in the same mode (visual, auditory, kinaesthetic) may also indicate to their subconscious that they are being heard. As an example, it is better to respond to ‘It feels as if someone is drilling into my knee with a screwdriver’ (kinaesthetic) by responding ‘So it feels really sharp and deep in your knee’ (kinaesthetic) than by saying ‘That sounds really painful’ (auditory) or ‘I see what you mean’ (visual).

The best way to gain rapport with patients is to value and respect them as fellow human beings, acknowledging that they have a current difficulty, but that they have within them many strengths, abilities and resources, even if they may have lost touch with them or be unaware of them consciously.

**Effective communication**

Working in a brief, solution focused way one needs to be able to communicate effectively. We need to address both right and left brain, conscious and unconscious, cognitive and emotional type processing, depending on which model you prefer. To bridge the gap one can use hypnosis, imagery and metaphor, which engage both types of processing (Danesi 1989). Often a patient with chronic pain will express themselves with a metaphor and this should be carefully noted and utilised if at all possible. For example “It feels like a heavy weight crushing me” could be explored by finding out what might make it feel lighter and this might be a useful approach to take in hypnosis as well (Martin et al 1992).

**Hypnosis**

If the health professional is using hypnosis formally in a therapeutic session this has to be discussed and any misconceptions the patient has need to be addressed. The most common one is that they will lose control and, unfortunately, this is fostered by the way media often portray hypnosis. Hypnosis, however, gives them much greater control over how they feel and the hypnotist is merely the navigator, the patient concerned is the pilot and can choose not to respond to the directions of the navigator. Hypnosis can be seen as a reduced focus of outer awareness with an increase in inner focus of attention (Gruzelier 2006; McGeown et al 2009). This is a naturally occurring state; common examples are getting lost in a good book or activity when one loses a sense of time and one’s focus and attention is completely absorbed.

Depending on the suggestions given, hypnosis is usually a relaxing experience, which can be very useful with a patient who is tense or anxious. However the main usefulness of the hypnotic state is the increased effectiveness of suggestion and access to mind/body links or unconscious processing. When someone imagines something in hypnosis (colour, sound, physical activity, pain) recent neuroscience findings show us that similar areas of the brain are activated as when the person has that experience in reality. (Barbasz 2000; Kosslyn et al 2000; Derbyshire et al 2004.)

The patient can then be taught self-hypnosis, which means they can enter this state deliberately at will, in order to utilise imagery and suggestion to help themselves (Dillworth et al 2012). In the clinical setting the health professional wants to avoid dependence and save time and money, and studies have shown that hypnotic interventions can be very cost effective (Lang & Rosen 2002).

Hypnosis can not only be used to reduce emotional distress often associated with chronic pain but to have a direct effect on the patient’s experience of pain (Jensen & Patterson 2014).

**Solution focus**

Exploring what was happening for the patient when they first started with the pain often gives useful information and when taking a history the health professional should focus on how the patient has coped, what abilities they have displayed in the past and when the pain varies (Bannink 2007). It is important to understand what the patient wants to achieve as this may not merely be a reduction in pain but to undertake other activities and social encounters that they currently feel unable to enjoy.

**Contracting**

Patients with chronic pain may have underlying difficulties such as poor self-esteem, loss and unresolved grief, or past trauma. Many may also be very regular attenders at the Primary Care Centre and on multiple medications. Being able to engage in a therapeutic conversation with rapport is vital in all cases but if several sessions are being planned it is important to be very clear from the outset on the time involved, the desired outcomes and how these will be measured. It is essential that the patient understands that there are no magic wands and that any successful outcome will be very dependent on their ability and commitment to use the strategies and tools they are taught.

There are many ways of measuring pain to be found in the literature, but the parameters the author has found the most useful are simple analogue scales for pain intensity and pain ‘bothersomeness’.

Often time is very tight and using a scaling question (Gingerich & Peterson 2013) at each session can give useful information as to progress and be part of the therapeutic intervention; “If 10 is where you want to be and 0 is the opposite, where would you put yourself now?” and “What are you doing that is keeping you from going down one; and what do you need to do to move up one on your scale?” This can be asked globally or about a specific symptom. Often the patient may find it easier to determine the answers to the second question when in hypnosis. Writing down their answers each day can be a useful homework task as it forces the patient to be specific in thinking of behavioural ways that they can help themselves.

**Homework**

Expectation and motivation play a large part in the effectiveness of any intervention and brief interventions puts responsibility for change firmly with the patient, teaching them tools and strategies, and giving them ‘homework’ to do. This ‘homework’ should be set in the frame of ‘experiment and observe’ rather than a test. Homework planning needs to be collaboration between patient and health professional, and carefully scheduled by the patient into their daily life.

**Anxiety**

Any anxious patient in a consultation with a health professional will tend to have a heightened and narrowed focus of attention and therefore be more ‘suggestible’; some would say they are already in a ‘hypnotic’ state (Lang et al 1996).

A patient with chronic pain may well also be anxious about what the future holds and therefore will be using their imagination to paint catastrophic scenarios in their head. One can utilise this imaginative ability and direct it in a solution focused way, teaching them to use it to focus on their goals.

**Depression**

Depression is a common comorbidity with chronic pain; the patient may feel that nothing can be done and their whole focus is on their pain. Helping the patient change that focus and understand that the depression is an emotional state they are ‘doing’ or ‘visiting’ rather than who they ‘are’ changes the dynamics of the situation to allow for change (Yapko 2001). Leading the patient to acknowledge that there are times when they feel more comfortable or things they can still enjoy, generates hope; for without hope there is no possibility of change. Becoming ‘mindful’ of the small things in life that might give pleasure such as a flower, the taste of food or drink, the smile of a passer-by, the warmth of the water in the shower, can all begin to change a predominantly negative focus. Using hypnosis and imagery to connect with calmness, peace and joy can be an important part of treatment.

**Expressive Arts**

Working with expressive arts, whether drawing, creative writing, music or movement allows for an external representation of the ‘problem’ and then a focus on the patient’s strengths and resources towards change (Angus & McLeod 2004). This can be an especially helpful approach when the patient has difficulties putting their ‘problem’ into words.

If a patient has difficulty expressing how they feel they may find it helpful to doodle, firstly how they feel now, and then how they wish they could feel in the future. It is important that they spend some time doing both and do not simply focus on the negative. They could then doodle as they focus on how they could move from one state to the other. They could use colour and odd words as well as doodles and may wish to share them with the therapist, or not.

The important part is the process, not the finished article. For those that are very judgemental it may be useful to suggest that they use the ‘wrong’ hand to hold the pen or pencil so that they do not expect perfection.

Working with expressive arts is one way to access the relaxation one feels when totally focused on a task and this is beneficial in itself, as the body enters a more restful, restorative phase. Some patients prefer regular exercise as a way of shifting focus and accessing a calmer state. By teaching self-hypnosis or meditation and the use of imagery a patient can learn lifelong tools that will reduce anxiety and help engage their inbuilt ability to help themselves.

**Self-hypnosis**

There are numerous ways that one can use to induce the hypnotic state. Focusing on the breath or doing a progressive muscular relaxation are commonly chosen. Some people prefer to just close their eyes and imagine engaging in some physical activity that they enjoy, such as running, swimming or cycling. Once they are really engaged, using all their senses, they can then take themselves to their special, safe, calm, happy place; real or imaginary. As an example: Mary, who suffered with chronic shoulder pain, imagined sitting under a warm waterfall and found that soothing and helpful in reducing her pain levels.

Patients have differing abilities in entering a hypnotic state but as with any skill, practice helps. This is important if patients are intending to use these methods to help themselves, but ten or fifteen minutes once or twice a day for three to four weeks is usually viewed as sufficient.

**Relationship with the pain**

Many patients with chronic pain view it as their enemy – something to be fought. Their attention must therefore always be on the pain, always on guard. Such a patient is liable to be in an adrenalin state and far from relaxed; and this in itself can increase the experience of pain.

Having an attitude of acceptance, but with the proviso that they will do all they can to help themselves be as healthy as they can, is a more resourceful state to be in.

Pain could be seen as rather like a toddler clamouring for attention from a mother busy in the kitchen…just telling the toddler to go away and play doesn’t work – they clamour louder and louder until they get attention! In the same way as a new mother will wake to a slight cry from her baby but sleep through other noises, so the pain can whisper rather than shout provided the patient takes heed and acts appropriately if the level goes up.

Giving suggestion whilst in a hypnotic state can be very effective and although this can be done verbally, this is where imagery really comes into its own (Alden et al 2001).

**Imagery**

Imagery can be an immensely powerful way for the patient to help themselves and should not just be visual but embrace all sensory modalities. As well as classic imagery to reduce pain such as turning down dials and disconnecting wires, client-generated imagery arising from the patient’s unconscious processing is likely to be more powerful and effective (Greene & Reyher 1972).

One way of utilising imagery is to ask the patient to simply close their eyes (to shut out external distraction) and begin to focus on their problem and to describe what image comes to mind. By the health professional asking questions about the sensory modalities of the image, such as “How does it sound? What colour is it? What type of surface does it have?” the patient is encouraged to really connect and make the image as vivid as possible (in effect entering a hypnotic state). The next stage is to encourage the patient to begin to make a helpful change in the image such as changing the colour.

*Angela, a fifty year old woman with persistent vulvodynia, imaged her pain as a dark purple vortex that was spinning in an anticlockwise direction. She gradually changed it to pale pink, slowed the spin and then reversed the direction of spin, with beneficial results.*

Once the patient is feeling more comfortable the health professional should then suggest that this comfort will continue once the patient returns to their normal conscious awareness*.* Practice is very important:

*Margaret suffered with endometriosis and was often in pain with abdominal adhesions. In hypnosis she ‘went into her tummy’ to take a look and imagined ‘healing fluid’ bathing her intestines and gradually dissolving her adhesions. She practised this for twenty minutes a day and after several weeks was virtually pain free.*

Chronic pain may respond well to simple symptom relief, but often underlying psychological drivers or triggers need to be addressed. Often patients with chronic problems may feel anger and frustration, both with themselves and those around them. Very often this is supressed or directed inappropriately.

A safe way to help patients release and deal with anger is 'Silent Abreaction', using imagery to allow their minds to 'let go' and disperse these strong negative feelings (Williamson 2008).

*The patient sits down, closes their eyes and visualises a place such as a quarry or a mountain, miles away from anywhere or anyone. There they find a rock that is suitable to become their anger. They imagine projecting all the anger they wish to get rid of into the rock, so that it becomes their anger…. They then break up the rock in any way that they think fit. They can smash it up with a sledge-hammer, a pick or even a pneumatic drill….*

*When they are satisfied with the end result and the rock is in tiny pieces, they decide what seems right to do with the dust that is left (usually sweeping or blowing it away). They then imagine going to an appropriate place to feel calm again and to bring some of that positive emotion back with them as they open their eyes and return to the here and now…*

It is important to get the patient to access calm feelings after smashing up the rock before re-alerting.

A complaint of constant pain that never varies in intensity should alert the clinician to explore and help resolve the underlying psychological problem.

*Tom had had a bad road traffic accident and still suffered with constant head and neck pain two years later despite no physical cause being found. While reviewing the accident using dissociated imagery in hypnosis Tom ‘remembered’ thinking as he was lying, trapped in his car, “My head hurts so I must be alive!” Working with this narrative (whether historically accurate or not is unimportant, this is what Tom’s mind ‘thought’ happened) we used imagery for Tom to update his ‘unconscious’ mind so that he truly understood that he had survived, that the accident had been in his past and he didn’t need the pain to let him know he had survived.*

If we believe that symptoms may be a bodily response to, or a way of dealing with, some underlying psychological problem then their treatment should include ways to resolve this or find alternatives that are more acceptable. This is most easily done in the hypnotic state as often these underlying drivers are not accessible to the patient’s conscious mind. But although hypnosis is extremely useful in these circumstances, these ideas can be explored outside of hypnosis (Brann et al 2011). Ideomotor response is a movement such as nodding in agreement or gesticulating while talking which is perceived as taking place unconsciously, and this type of ‘involuntary’ movement may be used to explore these drivers. The movement of the hands can be used to monitor unconscious processing.

This exercise can be useful as a self-hypnotic induction or just to help the patient with their problem. The author has taught it to many patients for them to use on a regular basis even when they have not had formal self-hypnotic training.

*The patient holds their hands four to five inches apart in front of them, palms facing and asks themselves internally if their unconscious mind is prepared to work on "x" now.*

*If the response is "yes" then their hands will gradually come together as their unconscious mind reviews the problem.*

*If "no" then their hands will move apart. This must be respected although they can maybe try again later.*

*Once their hands have touched, they then allow one hand to drift down to their lap as their unconscious mind gathers up the strengths and abilities and resources it needs to deal with the problem.*

*Once that hand has reached their lap, they then allow the other hand to move down to their lap as their unconscious mind starts to use these resources to help themselves with the problem.*

It is important with this technique not to make their hands move deliberately or to stop them moving but to let it happen by itself….to just wait and see what response they get.

**Conflict**

Sometimes symptoms arise because we know we ought to do one thing but we want to do the opposite or when there is indecision regarding two courses of action. One can suggest that the patient closes their eyes and considers this, and then maybe teach them the ideomotor exercise above.

**Organ Language**

Often patients use anatomical metaphors such as “I feel as if I am being stabbed in the back”…. “He gets under my skin”…”It’s a pain in the neck”.

One can ask the patient to close their eyes and consider whether, by using symptom ‘X’ their unconscious mind trying to tell them something.

Once the connection has been made and acknowledged an alternative may be found if needed but often the symptom simply disappears. Alternatively the client-generated imagery can be explored… “What do you need to do to take the knife out?”…”What do you experience as he gets under your skin? ...What is happening? What do you need to do for it to feel better?”… “How could you help your neck to feel more comfortable?”

**Serving a purpose - secondary gain**

This needs to be explored in a sensitive manner and often the positive gain of the symptom is not recognised consciously, but it may be that the symptom appears to solve a problem.

One can suggest that the patient closes their eyes and consider whether, although they do not want symptom X, is there at least one aspect of their life that benefits because they have symptom X? They can then start to find alternative solutions that do not require the original symptom. Ideomotor movement can also be used in hypnosis to explore and resolve these issues at an unconscious level but this needs the health professional to be trained in these approaches.

**Past traumatic experience**

This could be an event where the patient feared death or injury or felt helpless and out of control. Sometimes this can give rise to immediate symptoms or may be activated by a subsequent event.

You can suggest that the client closes their eyes and consider this. The traumatic event then needs to be resolved or the patient referred to someone qualified to do this. Often the patient needs to realise at an unconscious emotional level that they survived. Using dissociated imagery and ‘seeing’ the event from a distance reduces the affect and can be as effective as more immersive techniques which may serve to re-traumatise the patient.

**Identification**

Upon questioning it is not unusual for the patient with psychosomatic symptoms to volunteer the information that a close relative had a brain tumour if they suffer with headache, or died of bowel cancer if they complain of abdominal pain.

One can suggest that the patient closes their eyes and considers the question of whether there was someone close to them who had symptom X or similar? Once the link is acknowledged and any negative feelings of anger or loss associated with that person resolved then the symptom usually disappears.

**Self-punishment**

The patient who declares “If only…” may be suffering from appropriate or inappropriate guilt, which then translates into physical symptoms.

One can suggest that the patient closes their eyes and consider whether symptom X is some sort of punishment? If a positive response is obtained then the next question needs to be “What needs to happen so that you can begin to forgive yourself?” Another useful question might be “Did you intend harm at the time?”

**Imprint**

As mentioned earlier, when a patient is in a vulnerable state, maybe as a child or in states of high anxiety or shock, comments made may be accepted virtually unchallenged and become a belief.

One can suggest that the patient closes their eyes and considers whether symptom X relates to something that someone has said to them. Once they have become aware of the connection and resolved the feelings around it, the symptom resolves.

In all these cases it is important that the patient rests in the question rather than tries to find an answer. If you have no counselling or psychotherapy training then it is probably better not to explore underlying drivers formally and just help patients with using imagery. But even if not explored formally, if you are aware of these causes you may find that you can help your patient more effectively by picking up and expanding on something that they come up with spontaneously.

Conclusion

It may prove useful to indicate how the author uses these approaches with a couple of brief case studies to show how they can be integrated into a Primary Care consultation.

Eric was 57 years old and attended for a review of his analgesic medication and gave a two year history of herpes neuralgia. He was also somewhat depressed and not sleeping very well. He described the pain ‘as if someone was rubbing salt into an open raw wound in his side’ and stated that the only time he felt easier was when he was riding his horse. He was interested in exploring any approach that would allow him to reduce his medication and help him feel more comfortable so we decided to have a couple of half hour sessions and see if it would help. He was directed to my website which has information on hypnosis and some self-hypnosis and general imagery tracks that can be downloaded for practice.

At the first session he scored his pain as 8/10 on both intensity and bothersomeness. Hypnosis was induced by suggesting that he close his eyes and take himself back to riding his horse, seeing, hearing, smelling, feeling how his muscles felt, the temperature of the air and really ‘being there’. Suggestions of calmness and comfort were given and he was asked to score his pain again - which had come down to a 5. He was asked to imagine what his neuralgia looked like, to go down into where the problem was and see what image, if any, came to mind. He said he could see red wires that were sparking as if they were short circuiting. When asked what he could do to help, to make things easier, he was silent for a while and then said he was pouring soothing fluid down the nerves to calm them down. It was suggested that he could continue to feel this comfort and that each day he could ‘go inside’ and see what needed doing to help himself, when he did his self-hypnosis.

At the second session Eric reported that he had been feeling a bit better and had certainly found that self-hypnosis had helped him to sleep better. He had been using the tracks from the website but also liked his horse riding imagery. He rated his pain at 4. He also started talking about how he had felt when he had been made redundant 18 months previously. He felt angry at the way he had been treated and it was suggested that he could do a silent abreaction as described earlier. Hypnosis was induced as before and suggestions of calm comfort given verbally as well as Eric using imagery of his pain. This time the nerves were still red but not sparking and he felt he needed to make them paler and cooler with his healing fluid. He was also taught the ideo-motor hands exercise to do, with the intent of helping his herpes neuralgia, and it was suggested that he might do this daily for a while.

Eric was seen a few weeks later and reported that his neuralgia was much improved and he was using self-hypnosis and imagery on a regular daily basis; in fact he had started a part time job and didn’t think he needed his medication anymore, apart from occasionally at night.

Peter was 68 years old and suffered with osteo-arthritis and had persistent chronic lower and upper back pain. This responded only partially to analgesic medication and he was keen to try something new. Again by using the information and tracks on my website Peter had already started to do self-hypnosis before our first official hypnosis session and had found that he really enjoyed it and was a good hypnotic subject. This was a good starting point. We spent the first session exploring different ways he could use to enter hypnosis and he already had his ‘special place’ where he could feel completely calm, at peace and comfortable. While he rested there, suggestions for calm comfort were given and he was encouraged to ‘go into where the problem was’ and tell me what he saw. Peter focused on his lower lumbar spine and felt that some of the vertebrae were ‘out of alignment’ so imagined tapping them into place; higher up his spine he thought it was too red and hot so he altered it to a cooler, paler colour. When he focused on his cervical spine he imagined ‘knobbly bits protruding from the bones’ so he ‘took a file and smoothed them out’. His pain level dropped from 7 to 2*.* It was suggested that he could repeat this when he did his self-hypnosis practice.

At the second session Peter reported that his pain level had improved and was generally around 4 or 5. He was taught glove anaesthesia (numbing a hand in hypnosis) and transferred this numbness to his neck. In hypnosis he was reminded how we naturally only become consciously aware of a very small amount of incoming sensations, how we become so accustomed to something that we become unaware of it, how we distract ourselves and how he could become so focused on whatever he was doing or whomever he was with, that he needn’t notice his back. Suggestion was given that unless he needed to take some action to protect himself, his back needn’t shout at him and that he could remain comfortable.

Peter’s third and final session was tape recorded so that he could take it home to practise with. During the session we revisited all the ways Peter had used hypnosis and imagery to reduce his pain so that he had a permanent reminder of how he could help himself.

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